ALLIANCE FOR HEALTH REFORM

Medicare-Medicaid Coordination for Dual Eligibles: What's it all About?
Alliance for Health Reform
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ED HOWARD: —the Alliance of Health Reform and I want to welcome you today on behalf of Senator Blunt, Senator Rockefeller and our board to a program to examine the basics of a much discussed group of individuals and the federal policies affecting them. We're talking about people who are enrolled in both Medicare and Medicaid, the so-called dual eligibles. Now everyone's interested in dual eligibles these days. Not only are they among the most vulnerable of beneficiaries but they're also the costliest so anyone worried about the quality of care or about trying to wrestle with fiscal difficulties at any level of government is concerned about duals.

I need to note that the Affordable Care Act provision setting up the Office of Medicare and Medicaid Coordination can be traced pretty directly to the concerns about duals by the Alliance's Founder and Honorary Chairman Senator Jay Rockefeller. At the urging of Senator Rockefeller among others we've been holding several discussions of issues affecting duals and today we back up a bit and try to make sure that everybody understands the basics of who the dual eligibles are, how they're treated now, and what the prospects for change in that treatment are.

There's some very real policy disagreements about duals but today we want to make sure everybody understands the basics of the situation. We're not going to shy away from

controversial issues but they aren't the focus of today's briefing and we've asked our panelists to be as factual as they can. We're pleased to have as a partner in today's program WellPoint Incorporated the operator of Blue Cross and Blue Shield plans in more than a dozen states which in total cover about one in nine Americans. You're going to hear from WellPoint's Aileen McCormick in a few minutes.

We have a couple of logistical items to get to. In your packets there of course is a lot of information that we think would be helpful to you as you try to learn more about this topic including biographical information about our panelists. All of that information and more on our website allhealth.org so you can follow-up and share with your colleagues. There's a webcast that'll be available later in the week on allhealth.org, a transcript that'll be available a few days after that and finally, there are two pieces of paper in your packets that I want to call particular attention to. One of them is blue. It's an evaluation form we want you to fill out if you will before you leave to help us make these programs better. One of them is green and it's a card on which you can write a question when we get to the Q&A and we'll try to address those.

Let's get to the program. We have some great speakers and we have a number of speakers so we want to try to give them

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as much opportunity to speak as we can. I'm going to start with Michelle Herman Soper, senior program officer at the Center for Healthcare Strategies (CHCS). If you're not familiar with CHCS and you deal at all with Medicaid policy you should be because they are the go-to group for thoughtful and objective analysis of Medicaid. Michelle has expertise in Medicaid finance, delivery, managed care among other areas. She's had firsthand experience with tough Medicaid problems with her work in D.C.'s Medicaid operation. She's been at the National Conference of State Legislatures. She's been at Medicaid and CHIP Payment and Access Commission (MACPAC). Those of you who know what the new acronym commission is and we've asked her today to give us an overview of dual eligibles to get us started. Michelle, please. Thanks for joining us.

MICHELLE HERMAN SOPER: Good afternoon. Thank you, Ed, for your very nice overview of Center for Health Care Strategies (CHCS). My name is Michelle Herman Soper and I am a senior program officer at CHCS. We are dedicated to improving healthcare quality for numerous groups of people including people with complex needs which includes dual eligible. Like Ed said, I am here today to give you a brief overview of who the duals are and why national and state policy makers have made improving their care a key priority.

Very quickly, there are just over 10 million dual eligibles in the United States, so eligible for both Medicare and Medicaid services. We just very broadly looked at them for this slide in two different groups. One is people over age 65. The majority of those people qualify for dual eligibility based on their needs for long-term services and supports in Medicaid. The second group under 65 primarily qualifies for dual eligibility because of a severely limiting disability. Although not all duals have complex care needs as a group, they tend to be sicker and use more services and are more expensive which we'll talk about later in this presentation.

Who pays for which services? Medicaid covers primarily primary care and acute care including hospital services, physician services and prescription drugs among other services listed here. Medicaid covers primarily long-term services and supports. This includes nursing home care and home and community-based services on which varies among the states. They also provide to some degree cost sharing for Medicare premiums and other out-of-pocket expenses.

What does care look like today? Medicare and Medicaid are two distinct programs which were not designed to work together. Medicare is a federal program and Medicaid is a joint federal/state program. One of the biggest policy challenges facing both federal and state policy makers is that

the responsibility for administration oversight and financing for these programs is split between the federal and state governments. Without integrated care individuals may face three sets of benefits: traditional Medicare for hospital and physician services, prescriptions drugs or Medicare Part D, and Medicaid. They might have three different identification cards. There is also not in most cases an entity that works to coordinate benefits across programs so it can be very confusing to navigate.

Likewise, providers face a very confusing system. They generally work in one system or the other and there's not a broad channel for communication between the two of them to talk about different providers that the same beneficiaries might have. This system also can cause cost shifting between the federal government and the states. If one program covers a service there might be an incentive to shift beneficiaries to a different service for financial reasons rather than clinical. There are also a few incentives built into the current system that incentivize home and community-based services.

What is integrated care? Integrated care in our definition is one accountable entity that combines financing and delivery of Medicare and Medicaid services. This includes primary and preventive services, acute care, long-term services and supports, and behavioral health. There are many vehicles

that states and federal government can use to do this. For example, a health plan might take a blended rate from Medicare and Medicaid and coordinate services together. A provider entity can be responsible for coordinating across different delivery systems. There are a few examples of integrated programs today. Massachusetts for example has a program called Senior Care Options where a comprehensive health plan receives a blended payment for Medicare and Medicaid and provides the full spectrum of services for seniors enrolled. Arizona is another example of a state leader in managed long-term services and supports. As of a recent report, Arizona has more than 40,000 dual eligibles enrolled in the same health plan with a line to Medicare and Medicaid benefits which includes long-term care facilities.

As was already mentioned, the Affordable Care Act provided some new opportunities to better integrate services. Specifically, Section 2602 created the Medicaid Coordination Office (MCO) in the Centers for Medicare and Medicaid Services (CMS). MCO has of note established demonstrations in which the federal government, CMS, and states can partner to test new, innovative ways to deliver care for dual eligibles. They also created the Integrated Care Resource Center which is a state technical assistance center on which CHCS in partnership with

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Mathematica runs with CMS to help states implement some of these programs.

This slide I won't spend time on. This is just a graphic, a state of the states that shows where states are with their financial alignment demonstrations which I'll talk about now. In July 2011, CMS released guidance for two different financial alignment models. One model is a capitated model and this is based on a three-way contract between the states, the CMS, the federal government, and health plan. The health plan is responsible for receiving one blended rate and providing care across all service delivery settings.

In a managed fee-for-service model CMS and a state have a formal agreement which involves another entity, usually a provider-based entity that receives a payment for coordinating services across the spectrum. Both models are based in shared accountability between Medicare and Medicaid and shared risk and both models have potential savings built into the rates and the possibility to achieve those.

Five states have signed MOUs with a memorandum of understanding with CMS which is the first step to moving these programs forward. Massachusetts was the first state in August 2012 to do so. These states along with more states now are working with CMS towards developing an MOU which outlines what the program will look like. Some key issues and key decision

points are setting rate, thinking about the methodology, how do you blend a rate for complicated care across delivery settings, what supplemental benefits would be valuable to enrollees above and beyond what Medicaid and Medicare currently provide. How to appropriately measure quality and performance and how to balance enrollment choice to enroll in the demonstration with insuring a sizable number of people enrolled to make a meaningful change. These states have chosen health plans to participate through a competitive process. A couple states are involved right now in readiness reviews both on the federal and state side. No one has actually reached this point yet, but a few states are working closely with CMS to the go live point where they sign either a three way contract or a CMS state agreement, but a few are very close.

I've outlined ways in which CMS and the states continue to make progress towards integrating care. Many states intend to hit the ground running this year or next with newly launched models and much of the success and progress achieved to date has been the result of strong partnerships between the federal government and states and a wide range of stakeholders who are committed to improving the current system.

There are several challenges. This is a daunting task. It's breaking new policy ground and achieving this goal requires a significant amount of work, time, and resources.

Now states and the federal government are seizing unprecedented opportunity to make changes and working slowing and deliberately to insure successful implementation.

The last slide just has some resources from CHCS and ICRC if you want to learn more about the policy and thank you very much.

ED HOWARD: Very good. Thanks very much, Michelle. Now we're going to hear from Greg Moody. He's the director of Ohio's Office of Health Transformation. Ohio has been very active in the area of dual eligibles. It's one of the five states Michelle mentioned that have been chosen so far to be part of the duals demonstration. They have the memorandum of understanding, the MOU. Greg began developing his expertise in healthcare financing as a staffer on the House Budget Committee as I understand it, then under Chairman John Kasich. There's a familiar name. We're very pleased to have you come full circle and tell some of your former colleagues how this works on the ground in reality. Greg thanks so much for being with us.

GREG MOODY: Thank you. Very happy to join you representing the state viewpoint but it are a bit of flashback for me to be here. My time on the hill was in the early 90s. Rolling entitlement spending was the major concern. We were facing a fiscal cliff that led to a government shutdown at the time, some of the themes that I know you all are familiar with

today. We keep working on these issues and now work on these issues from the viewpoint of a state manager.

Governor Kasich became the Governor of Ohio in January 2011 so we've been doing this for about two-and-a-half years. He had an early insight that a lot of the challenges we're facing are because the system is fragmented and things are dropped in the gaps. That's true of how we organize our own state government so he created what we call an Office of health Transformation where I control strategic planning and budgeting across all of our health and human service agencies. It requires that kind of coordination to get things aligned and working together and the Medicare-Medicaid dual project is a perfect example of that.

We have a fairly comprehensive plan. One point I wanted to make is that any one of these projects does not exist alone. They exist in combination with other things states are trying to do to more forward an effort to improve health services while reducing costs. For us, we initiated a track on modernizing Medicaid programs in 2011. We led out with that because we had a budget deficit and we knew Medicaid was partly a key to dealing with that. We put the Medicare-Medicaid dual eligible project to the front of the line because we thought it had the greatest potential to both improve care of individuals and also save money.

The second tier here, streamlining health and human services, we're fully in the middle of now but it supports things like the Medicare-Medicaid dual eligible project, getting our eligibility systems modernized, getting our claims payment systems modernized. For us, we're creating a department of Medicaid, all things to get our own house in order to get these systems to perform better. We're just now starting and in fact, tomorrow I'll be in Baltimore for a conversation on payment innovation. Instead of just churning through fee-for-service how do we start moving to models of care that actually reward value and that's I think where we knit our Medicaid objectives into the broader healthcare system of rewarding value. We see the Medicare-Medicaid project as critical to that.

There's so much you can do. You have to focus in on something. For us, we focused in on a few people are very expensive. Generally, about 5-percent of us consume half of all healthcare spending and a subset that helps explain that are the dual eligibles. For us in Ohio, about 14-percent of the population accounts for 34-percent of the cost, often expensive because something in the system is broken down. It's very complicated to navigate, so how can you knit things together better to serve that small group of people better?

For us, we have this vision of better care coordination. Three days on the job, we had a two day turnaround for a deadline to apply for federal design funds to do a Medicare-Medicaid project. It was the best thing that could happen because we got our director of aging, Medicaid, mental health, and myself in a room and we literally sat at a computer and wrote this vision and everything we've done since that moment has been guided by this idea of a person-centered approach to cut through the fragmentation of the current system. We didn't get that grant but we liked our application so we did the work anyway. We're glad then when the process was opened up and we were then the third state to get approved to proceed with our dual eligible project.

There are several aspects of the program that I'll just touch on very briefly. This is how we're doing it. It's fairly straightforward. Everybody who's eligible for Medicare and Medicaid are eligible for our program. We are piloting in our urban regions, seven regions, 29 out of 88 counties in Ohio because we want to make sure we have networks that can handle the demand we're going to put on the system when individuals are seeking better coordination. We chose the areas where we know networks exist that will meet the needs of these individuals.

Our enrollment process, I skipped the detail on the last slide that for Medicare our dual eligible project is voluntary. As a state we would have much preferred that that bee mandatory. However, we accept that the voluntary of the process means folks will be able to choose not to participate in the program. We're making the enrollment process as straightforward, as education driven as possible trying to highlight the reasons why an individual will benefit from better care coordination so the individual can make that choice. It has turned out to be a very good discipline in our process to make sure we're making the kind of information people need available so they can make these decisions.

One of the key selling points for the dual eligible project is this massive array of benefits through Medicare and Medicaid. Not only that, but also local social services, a complete package of benefits an individual needs to stay healthy. That is very difficult to navigate today. You have multiple cards and you have multiple providers. In the state we have three or four systems designed separately to meet those needs, behavioral health over here, aging over here, Medicaid over there. This creates an opportunity for a single point of access for an individual into the system and we think that is going to have tremendous benefit to help them access these

medical services, these behavioral health services, and these community-based services all through a single point of access.

For us, we made a decision to go the managed care route. Other have gone the fee-for-service route. I think Washington is the one in the front of the line on that list. Most of the other early states have chosen the managed care route. We had a competitive procurement to identify the plans we'll work with to do this. The key is not just taking for granted their care management approach but we've taken a very hands-on role in what we think care management should look like and we've been very prescriptive in saying to the plans we want to see this type of model. Remember, it's a demonstration so we're really pushing as far as we can to see what new ideas in care management we can actually learn something from in these three years of demonstration.

Quality measures are required. For us, the key is we're a heavily institutionalized state. We have a lot of nursing home beds so for us a key quality here is our ability to divert in the home and community-based settings to avoid those other institutional settings. We have really focused on that as a quality measure and that is the key to our provider contracting. The wall I think some states have hit is the difficulty in maintaining political support for Medicare-Medicaid dual eligible project. We were very pragmatic with

our providers to say okay nursing homes we understand your concern. We'll just guarantee your rate. We're not actually concerned the rate is the problem. We want to divert people from not needing the nursing home in the first place. We were able to negotiate with providers in a way to guarantee certain network things and rates in a way that we were able to keep political stability and support for the model.

We're doing very well I think timing wise in getting this online. It is incredibly complex. I think we expected it to be that, but it is very complex. Medicaid at the federal level has gone out of their way to be creative and supportive. Medicare runs like Medicare has always run. Whenever we hit a barrier we solve it by saying we'll just do it the way Medicare does it. I've got to say that the process has been very constructive and I know it's easy to become disheartened as these things become extremely politicized. As a fairly conservative state, we've been working very well with the administration bringing this thing online because the objective is the same: improve care for individuals, save money for taxpayers. It's been a great project for us and I'll look forward to any questions you may have.

ED HOWARD: Terrific. Thank you, Greg. We're going to turn now to Lynda Flowers. Lynda is a senior strategic policy advisor to the health team at American Association of Retired

Persons' (AARP) public policy institute. She's held senior posts also with the D.C. Medicaid Agency and with the National Academy for State Health Policy. She's a nurse by training and recently was one of the authors of a major paper on how states could better assure the well-being of dual eligibles. We needed to hear the consumer voice on this panel and Lynda is the consumer voice.

LYNDA FLOWERS: Thank you, Ed and thank you the Alliance and WellPoint for convening this briefing and for inviting the AARP Public Policy Institute to bring the consumer perspective. I am delighted to do that for you this afternoon. I would like to start by talking about the essential consumer protection from the Public Policy Institute's perspective across nine domains and those would be a meaningful access choice, enrollment assistance, robust networks, care continuity, payment adequacy, adequate appeals processes, ombudsman support and oversight. I'll be giving you a high level overview of what we think are the important protections across those domains.

In addition, at the back of your packet I have additional materials that have state specific descriptions of the five MOUs that have been signed with CMS and some charts which you might think are Snellen charts but they're really

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designed to just sort of highlight where some of these protections are already in place in the MOUs.

In the first domain around meaningful access we've identified five key points that should span across the entire demonstration. That starts with outreach and education all the way to enrollment, all the way to service provision, all the way through the appeals process. You need to provide cultural competency and language access to individuals across that continuum. Access for hearing impaired, access for people with cognitive and physical impairments, access for people with cognizant disabilities and geographic access, so that cuts across the entire spectrum.

There should also be meaningful choice, and by meaningful choice we mean voluntary enrollments with no lock-ins. That is pretty much the current trend in the five MOUs. We are seeing some voluntary enrollment periods in most states within passive enrollment after the voluntary enrollment period and almost every state's MOU allow beneficiaries to change plans every month. The one state that I would call attention to would be California where they are not allowing people in L.A. Country among the eight counties in their demonstration to voluntarily enroll so they will all be passively enrolled.

In terms of other meaningful choices, marketing rules should avoid undue influence. I think most of the demos are

tweaking the Medicare Advantage marketing rules in that regard. There especially should not be unsolicited contacts to beneficiaries because it does tend to militate against their ability to make meaningful choices. There should be choice among plans and providers including unbiased assistance with identifying those plans and providers and then there should be opportunities to participate in service selection, when and how to receive care, and also to self-direct care so the four signed MOUs that are doing capitated arrangements allows beneficiaries to self-direct their care.

We also would like to see independent enrollment assistance, assistance with initial decisions whether to opt-in or opt-out with planned selection and enrollment and whether to change plans. The assistant needs to be language appropriate and culturally competent and available for people with varying disabilities. The provider networks need to be robust especially in the long-term services and supports arena. That includes robustness in both urban and rural settings so that you can support community based care. One of the strategies that some states have been using to insure that those networks are robust are to use secret shoppers calling around to see if networks continue to have open panels, calling around to see if people can still access some of their needed services.

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It's also important to incorporate traditional long-term services and supports providers whenever possible. Oftentimes, you'll find that when you're working with the traditional providers they may not have the expertise at the beginning to work with plans. They may not be on automatic billing, they may have processes that are outdated and not compatible with how the plans do their business. In many instances, the plans will have to bring these providers along, help them make the transition to be able to work seamlessly with the plans.

Again, timely payment payments policies are critical especially for the traditional long-term services that supports providers who may be just dealing right on the margins and need those timely payments in order to pay their workers and also insure that the beneficiaries receive care and services when they need it. We need to insure that there's geographic access to long-term services and supports. There are new technologies out there that people have been using to help them identify where the holes are in the accessibility to those providers.

Continuity of care is another important aspect of consumer protections. There shouldn't be abrupt terminations of beneficiary and provider relationships or prescription drug regimens. Almost all of the MOUs are making provisions for smooth transitions for people to access out of network

providers when they need to, when they have ongoing treatment regimens in process. There needs to be a smooth transition. If a consumer has to change providers plans should contract with the broadest possible networks including the traditional providers when feasible. They should also continue working always to broaden the provider network so it's not just a onetime deal but when you learn that beneficiaries are working with particular providers to be able to court them and to be able to persuade them to come into the networks would be a useful thing in terms of continuity of care for consumers.

We need to provide meaningful support for family caregivers including respite care and I think many of the signed MOUs to date have incorporated some of that although I think there's one or two that have left it up to plan discretion. I would say this is really an important of continuity because where you have family caregivers providing the bulk of care for these beneficiaries just to provide them with a little bit or rest and respite when they need it is an important aspect of keeping them involved and able to engage and continue to provide that care. I see it as a critical aspect of care continuity.

Then the adequate payment structure. This is both something that protects the beneficiary and it protects the plans and when the plans are protected, the beneficiaries are

protected. We need to have adequate rate structure so that plans don't skimp on needed care for beneficiaries, especially those with higher costs. We need good risk adjustment methods to avoid gaming with risk selection and also to make sure that our plans are not just cherry picking to get the lowest cost beneficiaries.

Adequate risk mitigation strategies are essential to help keep the plan solvent and there's a lovely paper that was sponsored by Community Catalyst in your packet. It was written by Ellen Breslin Davidson and Richard Dreyfus and it talks a lot about risk mitigation in dual demonstrations and it's a very good paper.

Medical loss ratios are useful to insure that most of the capitation is spent on improving care and quality and not on administrative cost. I think three of the MOUs include medical loss ratios in their provisions. It's all in that chart in the back so you can take a look at that.

There needs to be robust appeals processes so that the beneficiaries' right to have an external appeal is maintained and in all the MOUs we see that that right is protected both on the Medicare and Medicaid side. When it's feasible it's good to combine the Medicare and Medicaid processes in offering beneficiaries the most generous provisions of each of the Medicare or Medicaid process. I think in the California MOU

they are moving towards trying to develop a combined process. It's also important to give beneficiaries access to independent assistance with appeals both in the internal appeals process with the plans and in the external appeals process. It's very, very critical I think to provide aid paid pending which means that while the beneficiary's going through the appeals process that their benefits would be paid for by both Medicaid and Medicare. Historically, the Medicare program has not paid aid paid pending but this is something I think is critical to take another look at and to see how we're going to get those essential services to beneficiaries while they're in the appeals process.

It's also important to provide access to independent ombudsman programs. These people are essential in helping beneficiaries negotiate and mediate the appeals process and navigate that process to work through the external processes, to engage in case advocacy during administrative hearings, to provide ongoing oversight of plans, and to help report back. I see them as an essential component of the oversight process working hand in hand with other people that are providing this oversight. We think it's good to build on existing ombudsman programs in states as long as those programs are independent and are sufficiently resourced.

It's also important to provide robust oversight. Once these plans are in place and the contracts are written then the oversight process becomes the essential thing. States need to have adequate numbers of staff to oversee these plans and it's important to be flexible so that this can be accomplished in a variety of ways. States can use external quality review organizations, they can use their ombudsman's programs, they can rely on their consumer volunteers. There are a myriad of ways that states can expand their resources to conduct oversight. Oversight staff need to have the appropriate mix of skills so that they are able to identify both the acute, the primary, and also long-term services and supports oversights needs.

Multiple stakeholders should be used including family caregivers. It's also important to include the consumers on the oversight activities as well. Access to plan data helps people to better understand and realize whether the things that are in the contract are actually being undertaken so access to plan data is essential.

In conclusion, I would say it's really important to think broadly about consumer protections, that it's just not ombudsman or certain things but everything in that contract should be viewed through the consumer lens. When you're looking at the contract try to look at it through the eyes of

the consumer and how does doing these activities help protect the consumer. The contract provisions should be thought of as a comprehensive approach to consumer protection, engage multiple stakeholders in oversight and make sure that consumer interests are protected in every aspect of the contract requirements. With that I'll conclude and I'll look forward to your questions.

ED HOWARD: Thank you, Lynda. Next is Aileen McCormick. She's the CEO of WellPoint's western region Medicaid business unit. You may know that WellPoint recently acquired Amerigroup one of the most respected Medicaid managed care firms and they acquired Aileen with it I guess. She has a long history of management leadership in Texas and elsewhere. Now she's responsible for WellPoint's Medicaid operation in half a dozen western states. As several of our speakers have noted, there is a three way relationship that is developing in some of these states that definitely involves the plan that's going to actually manage the network. We're very pleased to have Aileen to tell us about how that works in some of the western states she's responsible for.

AILEEN MCCORMICK: Thanks, Ed. I'll try to move quickly and make up a little time so that you guys have plenty of time for Q&A. You just heard who we are so I'm still evolving from being an Amerigroup associate to now being a

WellPoint associate. The reason WellPoint I believe really was interested in buying Amerigroup was because we do have tremendous expertise in working with seniors and people with disabilities, both non-duals and duals. We've been doing that for 17 years and I've had the good fortune to be affiliated for the last 11 years in that arena. I will probably focus most of my comments around Texas. I do have California now. I picked that up as part of the WellPoint acquisition and I'm excited about it. It's a very different kind of state but I don't feel like I'm quite as well versed having literally just picked it up two months ago. I know they've signed an MOU.

What we're hoping really is to take a lot of what we've learned in both Texas and New Mexico which are two of my key states with seniors and people with disabilities and help inform some things that we do in California and in Washington which is one of my newer states.

This is kind of a cool looking circular chart that gives you a perspective of where the Medicaid business unit currently does have seniors and people with disability so it's the blue. Again, Texas is really kind of an interesting state I think to talk about and it really dovetails nicely on a lot of the comments that I think you've heard up to this point.

This is sort of another catchy little circular grid but it really does a nice job helping you see that within our own

space 52-percent of our population is Medicaid only. We have 37-percent that are duals. A very small percent, you see the four where dual eligible members, where we already are in fact providing a lot of the things you heard here this morning for both the member's Medicare needs under a special needs plan and their long-term services and support needs under the Medicaid plan. What this really should highlight for you is just how difficult it is to grow that under current policy which is why we're really very excited about all of the work that the states and the federal government are doing to try to really create a more robust program around dual integration. I will talk a little bit about my own bias as to why I think it's a great thing because I feel like we've been doing it since 2006 when we rolled it out in Houston with our Star Plus members and we've continued to expand it. It is a difficult program to really get meaningful size without some different policy around it.

For folks that are more verbal than visual this basically just outlines what was on the previous slides about sort of the makeup of our population. You know 354,000 of our members are aged, blind, disabled or seniors and people with disabilities. I think it's been really very much of an honor for me that in Texas we now cover about 110,000 seniors and people with disabilities and another 20-some thousand in New

Mexico. We picked up Kansas and we rolled that out in January and another sizable group of stakeholders as well. We like to feel like we have a lot of expertise. We still have a lot of learn but we learn every year and so I hope to be able to share some of sort of the operationally things that we've done to really inform good outcomes, respectful relationships, great integration, promoting independence, etc.

This is really one of my favorite slides and this really shows at the core the cornerstone of what we do with seniors and people with disabilities today is in service coordination. We recognized years ago, quite frankly, that it was important to integrate acute care services, behavioral health, home and community-based bringing in really all stakeholders, family caregivers. We modified disease management. It's not your mom's disease management programs where it's single disease focused because really we need to take a holistic view of this population who oftentimes have a lot of comorbidities in addition to very serious behavioral health issues.

We put a service coordinator, and these are folks on the ground locally. They go into the homes, they do in-home assessments, they develop very strong and solid relationships with the members that they serve. They promote self-directed. We're required in Texas by contract to report on that. We are

all about promoting independent living. We report monthly to our states on the number of members we've diverted from a nursing home by using home and community-based services as well as one of the most gratifying programs for me has been the reintegration into the community from nursing homes. We've had tremendous success both in Texas and New Mexico with doing that.

Go on to the next slide and this might be a little hard to see because it's got this color coordination. The all green is basically a non-dual. Take Star Plus in Texas as an example. A non-dual is a member that we have. They're on Medicaid and we provide their home and community-based services on the LTSS side. We provide all the acute so it is truly the model that everybody's look at for a dual demonstration project. We're coordinating all of those services. It's not fragmented, it's integrated. It's a single point of everything that that person may need.

One of the things that I've become very passionate about and so this may be more an opinion than a fact, it's really a fact based on full disclosure. I really do think that plans that have experience with home and community-based services with LTSS are better positioned to be successful in a dual demonstration project. It kind of goes back to some of the things that Lynda was stating. It's about understanding

that the network is very different. If you grew up in a commercial world doing provider relations and contracting it's not the same. The community-based providers, they are many times mom and pop shops. They're hand to mouth. We don't have claim payment strategies around 90-percent in 30 days which is what is required by our contract. We actually target 90-percent in 14 days or less because of a sensitivity to that community. The provider relations educational process is much more intensive than a physician or a durable medical equipment provider, if you will. We try to actually collaborate with other LTSS plans in the community so that these guys are hearing one message in a cohesive and coordinated fashion because it's already so confusing to start with. We usually have to do it multiple times. It's not a one shot deal and then you refer them to the webinar. You have to really be very willing to make the investment with working with that provider community. I think we've done a really good job of doing that.

For me, a dual demonstration, we do some of that now with our special needs plans as I mentioned earlier but it's really an opportunity to take all of what we've learned on the non-dual side, certainly tailor it for the different comorbidities and maybe age differences, different disabilities. Whatever comes with it sort of tailor those

programs to do more of building on the foundation of what we've developed thus far.

One of things that I think we're most proud of from our Amerigroup world now into our WellPoint world really is the convening of a national advisory board. It was the first of its kind. It's been very well received nationally. It's convened by Lex Friedan who's my neighbor in Houston. That's just a coincidence. I didn't have anything to do with convening. Lex is a nationally known force to reckon with. He has done just an outstanding job of really bringing people into the national advisory board and they have helped educate us on how to be sensitive to working with people with disabilities from a nomenclature, from how we sort of present little things as well as larger things in terms of continuing the fight on promoting independence.

Those of you who are familiar with Bob Kafka from ADAPT he's now a good friend. We really do try and be very humble about what we don't know, what we still need to know, and show that we're doing the right through our results. I will stop there and look forward to questions.

ED HOWARD: Thank you, Aileen. Thanks very much. Finally, we turn to the very patient Rodney Whitlock who is the health policy director for Senator Chuck Grassley here in the Senate and before that a senior analyst for the Senate Finance

Committee and for then Representative Charlie Norwood. He's helped shape most of the major Medicaid legislation of the last decade in one way or another. A little known fact: he's an academic teaching at GW at both the department of health policy and the graduate school of political management and we're glad to have him as a guest lecturer this afternoon.

RODNEY WHITLOCK: Thank you, Ed. I appreciate you having me here. It's been a long time since I've done one of these for you. I actually didn't know it would take you so long to forget why it is you didn't invite me to do these anymore. I'm going to try to in eight minutes or however long Ed gives me after he's playing with the clock to try to mix simplistic complex and help you understand the complexities what may be seeming to you a simplistic notion.

We start with the obvious question why should you care about duals? Duh, obviously you care about duals and you're not here for the free food. Somebody has told you, has convinced you, has you absolutely certain you should care about duals, but why. What is it about duals? You just know that they're important. We think about things somewhat simplistically sometime. We should just solve the duals, right and we do that with lots of subjects. Imagine yourself at a cocktail party and you're talking with someone about health policy. We'll set aside for a moment that you reached this

ruinous moment in your life where you're at a cocktail party talking about healthcare policy. Instead, think about what you want to say.

If you want to appear to be knowledgeable on the subjects of healthcare, you need simply say I really think we need more dual coordination, medical homes, and state flexibility. You need not know what any of those words mean. You do know that those are important though to what we're doing in healthcare so, therefore, if you say them you must sound smart.

Let me take you a little bit below that simplistic notion to talk about why these issues are actually complex. I'm going to try to use a remote control and speak at the same time and if somebody tried to hand me a piece of gum right now I'd probably pass out, but we will give this is a shot. Why do you care about duals? A lot of money goes here. Well we spend a lot of money and we spend a lot of money in this space. This is one of those that I think is really important for people to understand who want to tread into this space. If you took the duals as a separate program, if you pulled them out of Medicare and Medicaid and created onto them a third program solely of their own, that program in terms of its combined federal and state spending, inclusive of both the federal Medicaid spend, the federal Medicare spend, and the state Medicaid spend would

be larger in fact than the other two programs remaining and they have significantly fewer people.

We're here in this space because we're spending a lot of money and, as you may have noticed, your government is starting to care a little bit about the money it spends. We look at this and go holy cow, we spent all this money on duals. Let's do something about it. Simplistic notion again. We're trying to get over those simplistic notions. Let's try to break it down away from these simplistic notions to who are the duals. The duals are and octogenarian widow sitting in her home frail, maybe close to nursing home level of care, right? Wrong. The duals are in fact a very heterogeneous term. It's not one size fits all, it's Baskin Robbins. There is numerous flavors here to look at.

I will walk you through a little of it. It may be a little bit of an oversimplification but I'm trying to not go too deep into the weeds here. Absolutely, that frail octogenarian is a classic example of a dual and you will have those who are over 65 but they fit into two categories. You have people who are more healthy and less expensive and people who are less healthy and more expensive. The octogenarian widow may fit in that part where she is going to need more healthcare and she's going to be more expensive. That's somebody who is the person you're looking at, okay, what do we

do about cost there? We may have another individual though who's just over 65, who's on a fixed income, who isn't particularly sick, just needs help with premiums and then you'll have people on the continuum. We can address those who are the continuum if we like but they are different people. Then you have an entirely different set of people who exist under the age of 65.

A lot of people run around talking about duals without grasping that 41 percent (using Michelle's number) are under 65 years of age. Nearly two in five duals are not 65. They're not seniors. A lot of people struggle with that notion and getting that complexity understood. Those people are very different. We'll start with the one who is a worker who's been in the workplace who suffers an injury and becomes disabled. A coal mine worker is the one you use there. My uncle, he is a dual under 65. He had Hepatitis C and needed a liver transplant and the anti-rejection drugs drove him from the workplace. This is the type of individual who does not have a tremendous amount of income, has worked enough to be able to earn Medicare and qualifies then for both programs.

Then you have two further categories that we can break it down into that are even further different. We'll start with people who were disabled as a child before age 18 who then later become older than 18, they've become an adult and they

start to work. We encourage them to work. We want them to work. We want them to be out in the workforce. They're capable of being in the workforce and while they're out in the workforce they earn enough work quarters to then become Medicare eligible. At that point, the state Medicaid programs come running and says sign here. We'd like for you to be on Medicare because we'd like to give away a large chunk of our liability to the federal government, so you have those people.

Then you have another set of folks who are disabled prior to their 18th birthday and they become eligible through the old age survivor and disability insurance benefit. In other words, these are people who after their 18th birthday their parent become Medicare eligible and they then become eligible with their parent. This is the OASDI pathway. These are people who typically are not more likely to be in the workforce because they would qualify on their own. These are qualifying on someone else's benefit. The point being we're looking at very different people under the larger umbrella word duals.

Now, another complexity to throw out here. You know you're supposed to care. You're here in the room, you're being talked to about this, you care about duals, duals are important, duals, duals, duals. In Medicare the people who are expensive, expensive to the Medicare program and its acute

benefit with multiple chronic conditions and functional impairments, the majority are Medicare only. Got that? So now we're looking at wait, wait, wait, but you said this whole set of duals and they're like really expensive and now you're telling me the real expensive people in Medicare are not even actually majority duals? Make up your mind; which is it? Again, this is not an easy subject. It's complex. The fact is the majority of people who are expensive to Medicare are actually Medicare only. However, the question is how many of those people who are currently really expensive under Medicare only are slowing transitioning themselves to be duals? How does a Medicare program and a Medicaid program communicate to be able to let you know here comes somebody. They're going to be expensive.

Who are the most expensive ones you want to focus on the duals? You have to break it up there as well. You've got acute spending that's done mostly through the Medicare program and long-term services and support done mostly through Medicaid. Long-term services and support is going to be more expensive most often. It's room, it's board and then there are people who are utilizing LTSS who are simply going to be more expensive. There's also a split between aging and disabled. They have different needs. They have different benefit sets. Aging long-term services and support is typically shorter term

in nature.

For the disabled, long-term services and support could last years if not a decade or more, decades. When I had a visit early this year from folks from the Down's Syndrome Society, one of the advocates visited me to talk about her brother who died on Medicare. He had reached the age of 65 and become acute Medicare only.

I've got data, have seen data where the most expensive group within this set are the beneficiaries of the Old-Age, Survivors, and Disability Insurance. It's not the octogenarian widow. It is the people who got by way of their parent's benefit that could be there most expensive subcategory under the term duals.

What do you need to hear out of this whole thing? There is no magic wand. If you arrived here today and are hoping to have somebody explain to you magic wand solves duals, it's not that easy. If you are listening to this and you're thinking oh, my cocktail party moment's over. I'm not going to just be able to say dual coordination and walk away. If you're listening to these complex, difficult, and perish the thought, boring presentations that we're all giving to you and wanting it to just be simplified for you, well suck it up, sister. You're going to have to learn some public policy. [Laughter]

It's hard. These are complex populations. They are difficult to understand if you want to write policy. There aren't any simple solutions here. You're going to have to understand how they work together. You're going to have to look at them differently. You're not going to be able to say well we'll just solve the duals and walk away and go back to sipping your martini. It's not that simple.

As much as I love a good monologue, especially my own, I'm very much looking forward to the Q&A and I'm happy to open up the floor.

ED HOWARD: Great. Thanks very much, Rodney. Chardonnay not martinis, right? This is Washington. A quick clarification. You I think very nicely described the heterogeneity of this population. Is it fair to say the one thing they share is low income or they wouldn't be on Medicaid?

RODNEY WHITLOCK: Sure. That is the one thing they share but then underneath that term it varies wildly.

ED HOWARD: Now it's time to ask your questions. I see someone with a green card already holding it up. Great role model if you want to do that. There are also microphones at the back of the room on either side that you can use to ask a question.

Let me exercise a little bit of prerogative here to back us up one step if I can. You heard from Greg about how

urgent it was from the state's viewpoint to try to get a handle on the very high expenditure duals as part of controlling Medicaid expenditures. Surely there have been efforts in the past to try to deal with that population. Michelle and I were having a side conversation about why some of those efforts had not been as successful, harmonious, whatever the word is as you might have expected or that we expect to come out of this demonstration that you've heard so much about. What are the underlying dynamics of the current law situation before the ACA gave us this demonstration authority?

MICHELLE HERMAN SOPER: What I would note first is that states are responsible for providing long-term services and supports like we talked about and behavioral health services for the most part that are provided either in a long-term nursing facility or in the community. States have been moving towards developing more programs and more opportunity to manage care in the home and community because it's what most beneficiaries prefer and also because it's less expensive than institutional care.

The disconnect happens when you have a dual eligible who is benefitting from care in the home. You have a personal care aid coming in to make sure that a person who, for example, has a physical disability doesn't fall, can properly care for him or herself. The problem is, is that when something happens

on the acute side there's a gap in information and understanding from that system to the Medicaid system which handles acute and primary care services. There might not be a connection with a hospital if somebody has to go to a hospital. There might not be a connection with a primary care physician if something more clinical comes up.

I think that there is an issue with states working to manage benefits in the home and community for complex populations, especially benefits that are more social in nature that are social services and supports that are designed to keep people ideally out of the more seriously clinical environments like a hospital or skilled nursing facility. What happens is besides the lack of communication and coordination if these services are successful the savings accrue to Medicare program as opposed to the Medicaid program.

What these demonstrations and integrated programs generally I should say, not just limited to the demonstrations, try to do is to create a shared savings pool where reduced hospitalizations and other clinical care provided that results from efforts to keep people out of facilities and healthier at home is shared amongst all the players in the system.

ED HOWARD: That's very helpful. Yes, go right ahead. I should say not just for your benefit but for everybody who

goes to a microphone please identify yourself and keep your question as brief as you possibly can.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin. I'm a practicing primary care physician. My question is for the gentleman from Ohio. It seems to me the key to integrating all these various services is access to the same electronic medical record. I work in a clinic in Virginia and I saw a gentleman last week who'd just been discharged from what we used to call Virginia Inova Hospital, Fairfax Hospital. We have electronic medical records, they have electronic medical records, but it's not the same record. I had to send a nurse to scramble to find out — he'd been there for a week — what tests they had done and what they had found out. No one's mentioned medical records so far and meaningful use is all focused on management stuff and big data and not interoperability. Did you talk about that when you put together your plan for these integrated networks?

GREG MOODY: My goodness, you have hit a nerve with me. Back in 1992, Senator Bond and my boss at the time Representative Dave Hobson introduced a bill around administrative simplification to require standards that would allow electronic data interchange. We all thought that two or three years later we'd be ready to go, you know ATMs for healthcare. Here we are all these years later and finally, there is some traction now where EHRs are taking hold in a way

where it's different in different places. Sometimes it's a system that's driving it and providing it for physicians as health plans start requiring it. We have been very deliberate in our effort with the plans to move in that direction.

We're also a state that has several specific payment innovation pilots underway. For example, comprehensive primary care initiatives where the ability to share data in an interoperable way is the core of that project. We do have hope for it but it is a slow process. I do think for us the next stage is going to be moving toward some sort of general certification for health information exchange (HIE) that gets past building an HIE and says anybody who can do the work we can certify as an HIE. That's where we're pushing next for us but it's a long path. Every tool we have including the dual project we're pushing that issue.

DR. CAROLINE POPLIN: We have 400 electronic health records (EHR) companies and counting. Thanks.

BRENDA SULICK: Hi. I'm Brenda Sulick with the National Committee to Preserve Social Security and Medicare. I especially want to thank Lynda for bringing up the consumer piece. I am somewhat concerned. I think we all hope that these duals demonstrations will work well and improve care and also save money but many of the people who will be in them are very frail and most of the plans that will be working with

these populations don't have a lot of experience with the LTSS population. I guess my question and concern is about having protections in place on day one for these folks.

Mr. Moody, I was very happy in looking at your state's MOU that you do have an ombudsman role in your state. I guess a question for you or for anyone else who wants to answer is will there be enough resources for protections for these folks whether it's in an ombudsman program or something else. I think some of the states are going to build under current ombudsman programs which is great, but I think some are already understaffed and underfunded. How are we going to make sure that these folks have someone to go to who's looking for them on day one?

GREG MOODY: Thank you. We need a couple more states up here. [Laughter] That is critically important and that function is chronically underfunded. We're in the process now of essentially doubling our ombudsman program because it's been focused primarily on nursing facilities and we're expanding that to also cover home and community-based services. We have an independent oversight entity to which people can go.

I do want to slightly convert the question too into this understanding that there is a lot of capacity out there already but chopped up in different segments. We have an adult protective services focus, and we have an ombudsman program, we

have area agencies on aging. Part of the problem we're getting into with the dual coordination project is this idea of well now the plan is just going to have its care manager added to the mix. You've got a behavioral healthcare manager and you maybe in a hospital have a care manager. What you really need is air traffic control over all of the care managers. The problem is that we have multiple points of care management not coordinated with each other. I think when you knit that together to say at this moment you're primarily using home and community-based services, so our area agency on aging is in the right role to provide oversight for you and that the plan makes sure that's occurring. Then in that setting there has to be a connection there to making sure a person is safe at home.

If that person is then in a nursing home it's a very different setting and maybe there's a different care manager in that setting and the responsibility for that care shifts throughout, something like an ombudsman program making sure that that's taking place. I think it's more an issue of accountability throughout the network to make sure a person is safe and cared for connected to something like a traditional ombudsman program.

ED HOWARD: Lynda, go ahead.

LYNDA FLOWERS: I agree that the ombudsman role is essential and that it be independent and well financed is

critical. I do think it's also important to look at day one more expansively in the sense of the robustness of the readiness review process making sure that all of the things that we want in place to make these programs work for consumers on day one are there. I think we also have to leverage the participation of consumers, and advisory boards, and committees. We also could take a lesson from Tennessee where I think they're receiving real-time consumer complaints and concerns and so it's not just only going to the plan but also directly to the state. I think we need to view the oversight role more broadly, more expansively, and also continue to work toward very well funded and robust ombudsman's programs at the same time.

ED HOWARD: Go ahead, Michelle.

MICHELLE HERMAN SOPER: I also wanted to mention that this something that all of the states that we've worked with at ICRC take very seriously as does CMS. There is a grant opportunity available for states who have signed MOUs to get federal funds. What these grants do is help get these agencies trained up on what these demonstrations are, how this will change the current system, and what they can do to help people who are enrolled in them. Already a few states who have signed MOUs are taking advantage of that opportunity and that's something that I think will be helpful as well.

ED HOWARD: Aileen, there's a related question that came in on a card and the questioner wanted to know what kind of training you gave to your service coordinators which covers some of the same ground, want to make sure those people are competent.

AILEEN MCCORMICK: It's a great question. I think it's an area in Houston where the Star Plus program was piloted we were fortunate to at the time, the state allowed grandfathered LTSS service coordinators. We have found that really RNs are not always the best candidates for service coordination. Social workers, or folks who have worked with the community a lot of times from the fee-for-service world that we would hire over when it rolled into managed care. We had the good fortune to really develop a lot of expertise in understanding sort of what makes a good service coordinator.

Quite frankly, someone who isn't comfortable going into low income neighborhoods, who isn't comfortable with extreme diversity and more than just gender based but in every way possible, with some of the things they may have to confront from social issues. We really have worked really hard. One, to recruit using some model tools to really figure out if someone has the right personality to be comfortable and thrive in a service coordination environment in very low income neighborhoods.

Secondly, we do a three week training program of all of our systems that you would expect and then there's ride-alongs. We take senior service coordinators and we do ride-alongs with our newly hired. Quite frankly, with sort of the explosion of state's interest over the last few years of moving LTSS into managed Medicaid we actually take a lot of our Texas folks and we transport them. When we do the hiring and the recruitment in New Mexico, in Kansas, in Tennessee, in New York we used a lot of our folks who'd been doing this for 10, 15, 20 years and just transported them. It really isn't sort of just an easy skill set. You don't just learn it overnight and so that's primarily how.

JULIA MOORE: Julia Moore with the Pugh Charitable Trust. I have a question for both Greg and Rodney and it follows on the first question that was asked. Are you moving beyond electronic health records and looking at IT systems that will give you population level data?

GREG MOODY: Yes. Eventually, in Ohio that's really what you're after and it's not just a practitioner level EHR. Again, it's back to an interoperable environment and then what is the state's expectation as a catalyst to leverage that expectation with other payers too. That's why I think a lot of this is going to end up being a matter of payment innovation where plans — for us in Ohio there are five plans that purchase

85-percent of all health services in Ohio. If there was a common expectation around price and quality transparency among that group it could leverage that activity overnight.

The difficulty is as long as any one of us is pursuing that objective on our own it's difficult to leverage that result short of the state just trying to mandate it and you run into a different sort of opposition to that. If we can pay in that direction as a group, that's when I put up the slide of payment innovation that we're trying to initiate now price and quality transparency is the core objective of that.

RODNEY WHITLOCK: On the policymaker side we desperately want more data. I mean we desperately want encounter level data to understand what's going on out there. From our perspective of what we get, on the Medicare side we can tell you how much was spent in the state of Kansas in 2011 on tongue depressors. On the Medicaid side we can't tell you how many actual human beings were covered in Kansas in the year 2011. We are working to try to get MedPAC and MACPAC to actually talk to each other, use common data sets when talking about the specific population, but we're a long way away from where we need to be to be able to get the data produced and then bring it us so that we can make policy. It's a serious frustration.

ED HOWARD: There is a related question that came in on a card. Let me just flip it in here. The person wants to know if there's a policy conversation to be had about online medical records with respect to privacy. How does the Health Insurance Portability and Accountability Act (HIPAA) effect, I don't have time to read the acronym out, how some of the care transition programs are implemented especially when confidential information is passed between a healthcare and a community social service agency? I don't know whether Michelle has had any experience at CHCS with that. Are you preparing for some disaster potentials in Ohio, Greg?

GREG MOODY: I'd rather not share a disaster potential. [Laughter] Just because I can't let it go, in that Electronic Data Interchange (EDI) bill I mentioned ten years ago, because there wasn't companion privacy legislation there was one line inserted at the very end of that process that said if Congress doesn't enact a privacy law then the President has the authority to do that and that's what crated the HIPAA privacy standard. It was one now I consider not well thought out sentence in the bill. That's what led to HIPAA. I'll let others describe how it's affected how the plans have developed.

ED HOWARD: Rodney, were you an accomplice in that?

RODNEY WHITLOCK: I was drinking. It wasn't me. I'm not taking responsibility for that one. Again, this is an area

where we continue to struggle. We don't have the good answers on that. This is one where you can swing radically back and forth on the issue of personal information privacy and how people react to that. If you tell me you can stick a chip underneath my skin right here and if I'm not able to speak for myself somebody can scan it and tell all the things they need to know about me before they start sticking me with needles I might be okay with that. There are a lot of people who hear black helicopters in their sleep who would think very, very differently about that level of technology. They have equally strong feelings and ask us to solve the questions and that's not one of our strong suits around here.

GREG MOODY: I would just augment my lack of an answer to say I do think HIPAA is misused as an excuse to not coordinate. Much of this as it relates to privacy has been resolved in terms of what you can do and in most cases, you're able to share the information you need to provide clinical services. I think what we have to guard against is some attempt to use it as a reason not to coordinate and preserve the currently fragmented system which is not good for anyone.

MICHELLE HERMAN SOPER: I was going to add I haven't worked on this issue with states specifically but every state who has issued a proposal or has signed an MOU has a different approach to sharing information. All states are thinking about

this issue and are including provisions in their planning to address this. Again, it is what Greg said. Different providers need to continue to have similar information across a beneficiaries' spectrum of care to be able to effectively make some changes and improvements. This is definitely an issue where there's not one answer as to what states are doing and it really just differs.

SHARON PEARCE: Hi. My name is Sharon Pearce and I'm with the National PACE Association. I guess I was a little disappointed that not any of you mentioned PACE. For those in the room who don't know, PACE is the Program of All-inclusive Care for the Elderly was actually one of the original integrated care programs for the elderly. It exists in 30 states, 90 programs in 30 states serving about 25,000 duals. I would really be interested to hear from you all about what your thoughts are on where PACE might fit in the future of care for the duals understanding that ours is not a model that can enroll nine million people tomorrow but that we play a very important part in caring for people who have particularly frail, significant chronic care and long-term service and support needs.

RODNEY WHITLOCK: I knew it was you because my BlackBerry's going berserk for the last 20 minutes.

SHARON PEARCE: It was not me, I promise.

RODNEY WHITLOCK: It was you emailing me. It was either talk about PACE or you've got lettuce in your teeth. I knew it was you though. [Laughter] PACE is part of the solution. From our perspective, anything that does a better coordinated care model that produces better outcomes is something we all must be looking at. Where does it fit within the continuum of hanging out a hospice cough to coffin as people advance from — when they become a dual, when they are on Medicare and Medicaid simultaneously and advance along their needs to becoming more expensive. Where do they fit? How do they fit in relation to people who are on the end of the spectrum with very low cost and very low needs to the people who are extremely high cost, to the people that are moving into hospice? PACE fits, so yes, your public announcement is absolutely wonderfully well taken and my apologies for forgetting it and you won't hold it against me I hope.

LYNDA FLOWERS: I'd just like to add I agree with Rodney. I think PACE is absolutely a part of the solution. One thing that we haven't talked about a lot and when we talk about dual demos and we talk about enrollment sisters is whether or not we want to equip them with a broader set of information so that they know about the range of options that are available to consumers. That consumers get at least acquainted with all the options that might need their needs and

then they can say I'd rather go in this or I'd rather go in PACE. That is something that should probably be considered because a subset of people that might go into the demo or wherever might be more suited to PACE.

ED HOWARD: I don't know whether to ask the panel or you the question that came up on a card which is how do all of these demonstrations affect the PACE program. I guess I would ask it in the other direction as well. The national enrollment in PACE is relatively modest. Are there PACE sites that are planning to be integrated into these demonstration states?

SHARON PEARCE: From what I understand, and Michelle may know the answer to this better, the demos as they exist currently carve PACE out. People who are already in PACE who are participants in PACE programs are not affected. I think the rest of it is depending on the state. Some states have worked with PACE organizations to insure a role for them alongside the demos but they are not necessarily a part of the demos. I think that we agree with Lynda that I think the best scenario is one where there is a range options, both plan-based options and PACE as a separate standalone option for failed duals.

MICHELLE HERMAN SOPER: That's right and I'm not going to give an answer. I can't say with certainty that every single state demonstration proposal carves PACE out although I

think most of them do. I think states are seeing this as PACE is another alternative and in many ways, a very effective alternative to these models. People who are currently enrolled in a PACE program, unless they choose to enroll in a demonstration themselves they will remain in PACE.

PAUL COTTON: Paul Cotton from the National Committee for Quality Assurance. Thank you for an excellent presentation. Lynda, you stressed the importance of having robust networks for long-term services and supports and I understand where you're coming from. What we're seeing a lot of plans do, especially on the clinical side is to do narrow networks and they try to encourage people to see not just any provider but the highest value, high quality efficient providers. I'd be especially interested in, Greg and Aileen, if you have thoughts, is there a way to do that kind of value-based purchasing and that kind of network design in the duals demo or are we just not ready for that yet?

GREG MOODY: I think there is and I think it's an objective we're working toward. It is a matter of balancing this issue of familiarity at first with value purchasing over the longer term. For example, we have transitional things inside our three year demonstration where whatever provider you have when you're coming into the demonstration you get to keep that provider. Over time we start giving the plan some

additional ability to then identify preferred networks to then make those choices with the consumer over time.

We've thought of it as kind of three levels. We have the first year, the second year, and the third year. In that first year, you're protected to keep any provider you want. All the provider rates are protected in that first year but then the plan has a transition and then gains more control and actually, quite a bit of control over the network by the third year.

AILEEN MCCORMICK: I would just add it's been interesting. I came from a commercial world a long time ago and in the commercial world it was tighter networks and provider communities were very interested. You join Medicaid and you go out and talk to providers. They don't want L-commerce so they're happy to have everybody in the network so everybody shares the pain of the very low reimbursement that goes along with the program. Recently, particularly with a lot of emphasis on really trying to get away from a transaction-based model that just is fraught with challenges there is a movement to start looking at more real partnering. We've done a lot with provider collaboration strategies in Tennessee and in Texas in particular and providers are getting excited by that. If you set it up correctly, if there's appropriate sharing and incentives and quality metrics to base some bonus

payments and stuff on we're finding an interest where they want maybe more than they were interested in, in terms of the populations we serve.

The long-term services and support community is even more interesting because that's been sort of a hands off. Get everybody in and just leave it alone. We've been in Texas long enough where we're really ready to start testing that a little bit because there really are certain providers that do just a great job and have really developed certification programs for their attendants, less turnover, just better outcomes with the population that we are trying to serve as best as we can. As you might guess, you have to wade slowly into the water. We're working very close with Health and Human Services. We vet it with them before we do anything so it's not a traditional we're in charge of the network. We have the flexibility to do it but we appreciate the sensitive. We are though looking at more partnering even on the LTSS side because we think there's some better quality possibilities in doing so.

LARRY LIPMAN: I'm Larry Lipman the Executive Editor for State News with the AARP Bulletin. Ed, you began the program saying that we would shy away from talking about controversy and we've done a pretty good job of that so far.

ED HOWARD: You're going to help us.

LARRY LIPMAN: I'm going to help you now get back on track. It's seems to me that you've got to address at least something. What is the biggest policy or political hurdle toward coordination of dual eligibles?

ED HOWARD: Let the record show that Larry put his question on a card and I would say this to everybody who put a question on a card. There's some really good questions here. We're going to run out of time before we get to all of them so you should do what Larry did and articulate it orally if you really want to assure it's going to be answered. Having given our panel time to organize their thoughts, who wants to talk about political and other barriers or policy? Rodney, you know a little bit about both of those. I know from your academic —

RODNEY WHITLOCK: Somebody has controversial, give Rodney the choice. The first word that came to my mind was ignorance but that's not accurate. I mean we know enough about the policy area. I think the more accurate word is fear. We do things a certain way. We've done it that way for 48 years. To really get into the subject matter we have to be willing to look at it very differently than we have for 48 years. Doing the same thing over and over again and expecting different results there's some definition there. Does somebody — anyway, it has something to do with insanity. We have been doing this a certain way and it leads to certain outcomes. I think

Michelle mistakenly said earlier that these programs are designed not to work together to which she quickly correctly herself. Aileen and I said oh, she was right the first time, but what would doing it differently look like? That's scary. People don't know. Lynda's presentation was built solely around I think here are the things we all have to solve if we're going to do something like this. Totally legit, but I think it overstates greatly just what a wonderful job we're doing already today on so many of these issues maybe because we're afraid to do things differently. That I think is our biggest issue here quite frankly.

LYNDA FLOWERS: I would agree with that. From my perspective the buzzword of the day is patient-centeredness. I think that the real challenge is going to be to bring the provider community along to really be able to put the patient at the center of care. I guess you wouldn't call that a policy per se, but I think it's a seismic change in the way we deliver services and work. It's a collaborative process that more providers are not used to participating in. Unless and until we do that, and it goes back to your point about value-based purchasing, there is some sense of consumer buy in there. The consumer has to buy into this, understand it, want it. The partnering that has to go on with consumers in this new world order is tremendous. I think as providers and having a

provider we're not really trained or used to indoctrinated in doing that kind of a service delivery model. I think that's one of the huge barriers to really making integration what it can be.

AILEEN MCCORMICK: I have maybe a little different spin on what I think is a risk that does concern me because I do think it's a great initiative and I think that's going to be the devil in the detail on the pricing of this. If CMS decides they want to take all the potential savings that LTSS can provide on acute care cost trends and then roll it out as a shared price the states aren't going to be as eager to sign up for that. They want to be sure they really are going to get the benefit for the improvement that the LTSS utilization has on those acute care costs.

ED HOWARD: Let me offer you up a couple of candidates for Larry's question that you can bat around and one of them is related to that. The other side of that is traditionally Medicaid rates in a lot of states have been represented as substantially lower than other rates that providers are used to. There is a question in here about how the rate negotiations are going in these states and whether or not they're going to allow an adequate level of care given the other kinds of requirements that you have to meet.

The other question that several of you have alluded to one way or another is whether or not you're going to be able to put these duals into a plan whether it's passively enrolling them and letting them opt out or Greg noted that would have far preferred to be able to put people in on a mandatory basis. Are those sore points that are going to slow down things not just in Ohio but in other places where there are some others who are related to those or do we not want to talk about controversial things which is what I suggested at the beginning?

LYNDA FLOWERS: I think most states are sort of looking to take the path of least resistance which is to offer that voluntary period with the exception of California that didn't do that for seven counties. Most states are saying voluntary for a certain period of time then the passive enrollment with the monthly opt-out so that sort of seems to be the middle ground at this juncture and we only have five signed agreements.

ED HOWARD: Does CMS have the authority to in effect waive Medicare beneficiaries' right of choice?

MICHELLE HERMAN SOPER: CMS has been very clear that no demonstration programs will waive the choice. I should also say just to add on to Lynda's point in the few states that have reached the point of designing a voluntary enrollment period

there's also a period before that where the state working with the plans that have been selected can provide information and conduct outreach and education to beneficiaries. They're not just thrown into the system and said oh, you can choose. There's information provided at least two months beforehand so they can make more informed decisions.

AILEEN MCCORMICK: I think one of the things I hear — I'm more at a state level. I'm meeting with the state and all the plans are in there and one of the things that's been interesting to me with this dual demonstration, take Texas for example. They're going to use their Medicaid Star Plus plans. They're not doing an RFP. They've made the decision that's the way they're going to go. Well there's a lot of pure play Medicare guys that feel threatened by that, aren't real happy as you might imagine. The question becomes if we do passive enrollment with an opt-out Medicaid plans — the way this is going to work and the way we think you get better savings is you don't want a big marketing infrastructure. Medicare plans spend a lot of money on marketing. If we can get rid of that that's great but if you still have these traditional Medicare plans out there who are spending a lot of money or the Part D plans who are spending a lot of money on marketing and advertising and sales forces, how is that going to impact our ability to be successful in keeping these members because they

are very easily confused. I don't know what goes on in the home because I'm not in there selling, so whatever happens it seems to work.

We saw that in 2006. We rolled out a special needs plan. CMS agreed to a passive enrollment. We enrolled 11,000 dual eligibles in. It was the same year Part D went live and I never saw anything like it in my life. These people were confused. They were getting barraged with guarantees and promises and commitments and disenrolling and not knowing that left Amerigroup and then wanting to reenroll. You can create a real chaotic situation. I do worry or wonder how that's going to impact these dual demonstrations because that mix of marketing tactics will be out there.

LYNDA FLOWERS: I think that's where a really, really robust single point of entry kind of arrangement in states and really well trained enrollment brokerages are key. Consumers should have a range of options and they should know what those options are and how they best meet or how they may not meet their needs. We don't want to get rid of PACE or this or that just because we want to make it simple but we want people to end up in the plan and the type of service delivery model that's right for them based on their particular circumstance.

In my mind, it calls for a broader concept of the enrollment broker than what even I had been thinking about in

terms of the demos. I had just been thinking oh, just tell them what the demo options are but maybe it calls for a broader, expansive role for the enrollment broker.

ED HOWARD: Yes, go right ahead. We have time for this question and that question.

NINA MARSHALL: My name is Nina Marshall. I'm with the National Council for Community Behavioral Healthcare and I have a question about the evaluation component of the demonstrations. These are supposed to be testing out different models and as we talked about at the beginning, this is a really heterogeneous population that we're serving. I will ask any of the panelists do you have a sense from the MOUs that are already completed and the conversations that are already happening around developing the quality outcome measures? Whether or not we're going to be able to effectively evaluate whether these work for different specialized populations, particularly folks with behavioral health and serious mental illness?

MICHELLE HERMAN SOPER: I would answer that and say that there's a two level answer to that. First, in the MOUs that have been developed, and Greg can definitely speak to the Ohio one better than I can, all of the MOUs include quality measures that are core to the demonstration, so agreed upon by CMS and the states that have signed to the MOU. The core

measures are very similar across different MOUs, not exactly the same, but very, very similar. The MOUs also include state specific measures that are specific to the population. For example, Massachusetts has an MOU for a demo that targets people age 21 to 64, so per Rodney's point that it's a very different population than a demonstration that enrolls people over 65 only. Those measures are going to be different than a demonstration that does that. These measures are also performance measures that are also tied to quality withholds in the rates that plans have to meet in order to get that amount of money back and that percentage increases every year for three years in terms of how much is at stake.

CMS has also hired RTI which is a large firm. It's their external, independent evaluator. They're developing both a national approach to evaluating these demonstrations so they will have some measures of comparison across beneficiary experience and care coordination, access to services, supports in the community and a whole range of items as well as conduct state specific evaluations. Those details are still being worked out now but they will have that component in place.

CYNTHIA J.: Hi. I'm Cynthia from the National Academy of Social Insurance. My question actually dovetails nicely with that one. It's for Greg. Above and beyond the core CMS measures Ohio seems to be one of the only states that serves

that population that included an array of long-term service and supports quality measures as well. I was hoping you could comment on the thinking or process behind incorporating the specific long-term care measures in the MOU. A second part of the question is a key aspect of robust oversight would be the contract management teams. I was wondering how those are shaping up in Ohio and if there are any models out there that Ohio is using to develop those within the three way contract.

GREG MOODY: I would have to ask John McCarthy our Medicaid Director on the second part of your question. This issue of why some of those measures, this is critically important for us because we are crossing a key line in Ohio where before behavioral health was carved out of care coordination and long-term services and supports were carved out of care coordination. What really happened is they were carved out of where the real resources are. The real resources have been through the Medicaid managed care program in Ohio. Behavioral health has been chronically underfunded. So what was kind of an advocacy viewpoint at some point in the past has resulted in a horribly underfunded system currently.

The dual project allows us now to re-cross that line and carve in behavioral health and carve in long-term services and support so we can have a single, unified budget around the individual to provide the services they need. We pay nursing

homes in Ohio too much so when our actuary is setting rates that pulls a whole lot of resources into the value of our dual benefit that then is available, ideally not to go back into that nursing home, but to avoid it by funding behavioral health and other home and community-based services to avoid it.

Back to the question about what was controversial. For us in Ohio, every time we hit something controversial where our normal instinct was to take our stand instead we said we're just going to let that go. Because it is so important to get the program up, we believe people should have a choice of a plan but not a choice to stay in a fragmented system. We would have made the Medicare enrollment in care management mandatory but when CMS drew that line, instead of walking away we said we'll cross the line with you the way you want to do it.

When our nursing homes were ready to kill this in our state legislature we said we'll just guarantee your rates to get it through because we have to cross the line into the territory where we have a model functioning to see if we can get it to work. There is a tremendous amount of practical, pragmatic improvisation that's required to get these things to work and I think it's why we have five states that have crossed the line and a number of states that are trying to get there. You have to be very pragmatic to cross that line.

ED HOWARD: Pretty good way to bring this conversation to a close. It's been a terrific one I think. I sort of wish I was John Stewart and I could say just go online and we'll continue this conversation for another hour. But I do want to thank all of you for keeping this conversation not only going, but going in a very high energy and very informative direction. I also want to thank you for what you're about to do which is to pull the blue evaluation sheets out of your packet and fill them out to not only validate the experience that we have had here, but to help us to improve these programs.

I want to thank our friends at WellPoint not just for supporting and cosponsoring the briefing but giving us Aileen who's made such a great contribution to the panel as well and ask you to join me in thanking the panelists, all of them for an incredibly rich and useful conversation.