Medicaid Innovations: Can Managed Care Cut Costs and Improve Value?
Alliance for Health Reform
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DEANNA OKRENT: Good afternoon. Please continue eating but take your seats and settle in. As you can see, we have a very full panel for you today and a very exciting program. My name is Deanna Okrent. I'm with the Alliance for Health Reform. And I'll be channeling Ed Howard but he's not here today.

I want to thank you and welcome you on behalf of Senator Rockefeller and our board of directors to this program on improving quality and value in Medicaid throughout the country. Medicaid is the federal state partnership that covers – we're projected to cover 70 million people for one month or longer in the year 2011. So it's quite an extensive program.

To set the context, these are trying times for the Medicaid program for its beneficiaries and for those who run the program. On the one hand, in almost every state, Medicaid has been under the budget cutting scalpel, to use a medical term because we have some physicians here to speak to you today, as legislators and governor struggle to balance their budgets. Now they await anxiously to hear what the super committee has in store for them as they deliberate and possibly make changes to Medicaid.

At the same time though, we know of big changes that are coming down the pike in the years ahead for Medicaid. And states are scrambling to prepare for those changes. Under the

health reform law, a major expansion of Medicaid enrollment is scheduled to begin in 2014. Not that far away any longer. The catch 22 is that states can barely afford to keep their current enrollees let alone enroll new ones. And the law requires maintenance of effort to qualify for the federal match.

So what tools are at states' disposal to manage the rising tide of Medicaid costs while maintaining their services to beneficiaries and offering quality programs? We're going to hear today from a distinguished panel of experts about how states are dealing with this dilemma. We'll look closely at one particular tool, Medicaid managed care, though it's not the only tool in the toolbox. As states struggle with budget challenges and seek ways to reduce their Medicaid expenditures, managed care has become increasingly popular.

We'll look at what's going on in the states and whether managed care is an appropriate approach for all populations. We'll hear about a recent 50-state survey of Medicaid managed care. We'll hear an on the ground perspective from one particular state, Missouri, and how it's managing its Medicaid program and budgetary challenges. And then we'll hear about a variety of states and what they – the options they've chosen and what they've learned from their experiences.

Then we'll hear from a major Medicaid insurance plan about its work to improve quality, to improve care delivery and

reduce costs by managing care. And finally we'll hear a cautionary note about using Medicaid Managed Care for the highest cost, sickest population known as dual eligibles. Should be an interesting and thought-provoking program.

We're pleased to have as our partner in today's program, the Centene Corporation, which contracts to provide Medicaid coverage in over a dozen states serving 1.5 million members. There's a one page fact sheet in your kits. It's on the right side around the – where the presentations are. It'll tell you a little bit more – the details about Centene. And in case you're not familiar with the Centene name and it doesn't sound familiar to you, you'll notice that the program has different names in different places. And that's why it might be new to you.

But before we turn to our expert panel, there are a couple of housekeeping items that I want to cover. Here's where I channel Ed Howard and tell you about that blue evaluation form in your packets that we like you to fill out. We really do pay attention to the comments you have to offer. There are also green question cards you can use at the appropriate time to submit questions to the panel.

And the materials in your packet, there are a great number of materials in there. Some we did not print. They are all up on the web site. We just try to be conscious of saving

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trees and we're trying to print a little less these days. But the materials are all available on our Web site at allhealth.org.

Now as I promised, we'll turn to our expert panel. And I'll say just a few words about each one as it comes their time to speak. But there are more complete bios in your packets for your reference.

First we'll hear from Vernon Smith, on my right at the end here. Vern is a principal with Health Management Associates where he focuses Medicaid, Medicare, CHIP, state budgets and trends in the healthcare marketplace. He's a national expert, a popular speaker on these issues and you may have heard him speak at any number of meeting such as the National Governors Association, National Conference of State Legislatures, National Association of State Budget Directors – Budget Officers, I'm sorry and various medical and hospital associations as well as committees of the U.S. Congress and others. And Vern has also been a state Medicaid director in Michigan. Vern.

VERNON SMITH: Well thank you. Thank you Deanna. And it's a great privilege to be here today. And particularly to talk about this topic which is very central to what's going on in Medicaid these days.

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My goal; what I was asked to do is provide a bit of an overview about what is happening with managed care in Medicaid. And my remarks are based in a substantial part on a survey that we did with the Kaiser Family Foundation that was published just in the middle of last month. And one of my co-authors, Julia Paradise, I see sitting over in front the screen over on your far right. And so, any tough questions, Julia will be able to handle those. [Laughter].

But, this survey, like the survey that was released – the report released yesterday on Medicaid budgets, is based on input from all 50 states, Medicaid directors and their staff around the country.

And the Medicaid managed care comes in more than one flavor. When we think of managed care, we most often think of HMOs or managed care organizations, MCOs. The states contract with MCOs for a comprehensive set of benefits. States pay MCOs on a capitated basis of per member per month or PMPM. And for that, the health plans are expected to provide a comprehensive set of benefits and to conform to an extensive set of requirements.

The contracts that health plans signed with states specified that they will guarantee access, that they will provide data on specific measures of quality that they will participate in annually qualify improvement and performance

improvement projects. They must agree to external review of their operations and of their performance on healthcare. And states often add other requirements as well. For example, they may be required to be accredited by NCQA.

In addition to MCOs, states also, in some states, administer managed care themselves in an entity known as a primary care case management program or PCCM. In a PCCM, the state contracts directly with the primary care providers. And those primary care providers agree to extra requirements above and beyond that which is required to participate in the Medicaid program itself.

For example, number of office hours at a given location, specific credentialing. They agree to organize and coordinate the care – manage the care especially with specialty care. They – and again they have to guarantee access and they have to agree to measured on quality measures. And for all this, the primary care doctors are paid an extra case management fee, often $3 or $4 or $5 a month.

So what managed care offers states whether it's a PCCM or an MCO is a point of accountability. That is something that is not there in the unfettered fee for service system. Sorry, I almost said unfedered. [Laughter]. So they're –

JUDY FEDER: I'm responsible for a lot but not that.

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VERNON SMITH: So, what states have here is a point of accountability, of guaranteed access, the ability to measure the care which is provided – the quality of care, organize and structure within which to bring about improvement and quality. And for states also it brings about some budget certainty and the potential for cost sharing.

And I was really struck when we were interviewing Medicaid directors for our managed care report. One Medicaid director said, "The costs are about the same for them. But if you take into account access and quality, you're getting better value. And right now states are really looking at what they can do to get better value for the tax dollars which are there to support the program."

Now when you look at the trend – the longer term trend, over the last 20 years there's been a substantial increase in the use of managed care in Medicaid. In the decade of the 1990s, Medicaid – the proportion of Medicaid beneficiaries in some form of managed care meaning in this case MCOs or PCCM, increased from less than 10-percent to 50-percent so a five fold growth in that decade. In the most recent decade from 2000 to 2010, another one third increase in the proportion of Medicaid beneficiaries in managed care going from 50-percent to 66-percent. And you can see the growth was primarily in the use of MCOs although there was growth in PCCM as well.

Now when you look at enrollment last October a year ago which was the point in time we used for measuring enrollment, our survey was actually done last spring. But when you look at last October's enrollment, you see this 50-percent in HMOs which amounts to 27 million of the 54 million, about 9 million in PCCMs. So that's about 16-percent. But that leaves about 18 million individuals, about a third of all people on Medicaid in the unfettered fee for service system.

So, when you look around the country to see the distribution of MCOs and PCCMs, you see that about 35 states – well about – I say about and actually that's the way to say. 35 states plus D.C. have contracts with MCOs. And we have 31 states operating PCCM programs. And 19 of those states are operating both at the same time in their state.

Now this map is ever changing which is why I said about. For example, Texas had an RFP and has awarded contracts for next March to begin to phase out its PCCM and move to rely on MCOs. Kentucky is phasing off its PCCM and moving with all MCOs. Connecticut is ending both its MCOs and its PCCM and moving toward an ACO model. New Hampshire which now is one of the three states with no managed care at all is planning to contract with MCOs beginning next July. So this map is changing all the time.

When you look at the MCOs in the program, you see that there is a real mix in terms of the characteristics of the MCOs. Fifteen years ago, there was no such thing as a Medicaid only managed care plan. Because federal law required that all the MCOs that states contracted with had to include commercial members. But with the BBA in '97 that changed and now 63-percent of Medicaid beneficiaries are in Medicaid only health plans. It's about half and half in terms of for profit non-profit. 42-percent are publicly traded and about half and half are either local plan – are local plans or national plans.

Now the thing that you see Medicaid now which is actually pretty exciting to look at is what states are doing using the platform of managed care to improve quality. There is a lot going on. And I was really – it was – I was really struck by what Craigan Gray, the Medicaid director of North Carolina said at the event in mid September when our report was released. He said, "We are unashamed to use the power of Medicaid to improve the healthcare for all the citizens of our state".

And that's what you'll see Medicaid programs doing now. States have really hit their stride in terms of using managed care developing information so beneficiaries can make better decisions, developing information so the state can make decisions about who to include and who not to include, having

information so they can identify good quality care, good performance and reward it and penalize poor performance and poor outcomes, developing reimbursement strategies that are very powerful tools, pay for performance in other ways, withholding from capitation [inaudible] a broad range of things which I wish we had more time to talk about here today. But this is what states are doing.

The interesting thing is that although we have two thirds of Medicaid beneficiaries in managed care the major of money is not. When you look at those two thirds, the account in those most recent information we have, just 21-percent of all of the Medicaid money is flowing through managed care. And the reason for that is that states typically had started with the populations that are most like employer sponsored health insurance populations; families and children. And the seniors and persons with disability and certainly the dual eligibles, which account for 40-percent of all Medicaid spending, have been excluded from managed care.

That is changing now as states are beginning to incorporate the seniors and persons with disabilities, children with development disabilities and certainly dual eligibles. A lot of activity creating integrated coordinated delivery systems for that population now across the country.

So, what we have now is that managed care is assisting states to achieve the most important goals of the program. Access and quality and what is, of course, a perennial priority, control of the cost. So the question of the day is can managed care cut costs and prove value and the answer is yes, it can. States across the country are demonstrating that's the case. If it's done right, it can be a very valuable tool for states. Thanks.

DEANNA OKRENT: Thank you Vern. And next we're going to hear from Ian McCaslin who has served since – over here on my right – who has served since 2007 as director of Missouri's Health Net which is Missouri's Medicaid program. Dr. McCaslin is a pediatrician and holds an MPH in health policy from the Harvard School of Public Health. He has held faculty appointments at several prestigious medical schools including Harvard, the University of California San Diego and the George Washington University School of Medicine right here in D.C.

No doubt a Cardinal's fan, we're particularly honored to have you leave World Series territory [laughter] to come visit us and share Missouri's story. Ian.

IAN MCCASLIN: Thank you Deanna. I have to admit to start off here I'm a little jealous. I did stay up for the game last night. I hope everyone did. It's one of the most amazing games [laughter] I've seen in a long time. But guess

who was at the game last night [laughter], my good friend, Mary. Was it as fabulous as it looked on TV?

MARY MASON: Well the rally squirrel got me here so. [Laughter] Little worried about the close flight but yes, it was wonderful.

IAN MCCASLIN: So we're holding out for tonight. It's my great privilege to be here. And I do thank you Deanna and to the Alliance for the opportunity to represent the State of Missouri and the 900,000 participants. We use the term participant. We like that idea of active engagement as opposed to beneficiary in the State of Missouri. And I'll tell you a little bit about what's going on in our program.

Big picture what do we try to achieve in our Medicaid program? And I really echo that settlement from Craigan Gray. Our goal is to serve all the citizens of the state to improve the health status of every Missourian. And we believe that with the purchasing power of the state Medicaid program that we have a lot of leverage. And particularly looking forward to 2014, we're going to exercise our muscle to improve access, quality and accountability to the tax payers.

On the tax payer side on the accountability side, it's a tough time for states. Missouri's in a better position than many. We're staring at a $500 million global budget deficient. And as you can see MO HealthNet, the Medicaid program is right

there in the lightning rod position with elementary and secondary education.

So any consideration of managing the state budget, closing a budget deficit, there's no way that Medicaid can left out of that. And we actually look forward to some of those conversations. We still have a few tricks up our sleeve although we've been doing this for three or four years now. And a lot of the low hanging fruit is gone.

Here you see our population broken out by eligibility group. We are a very traditional Medicaid program in terms of our coverage. We do not cover childless adults in the State of Missouri. It's very apparent that the intensity of span as Vern references in the seniors and those with disabilities. As a pediatrician, I love it that children are cheap. They're easy to cover. And we should be covering all the children based on the cost.

But our focus is very much on those individuals with disabilities and the seniors. And I, in a managed care presentation, have to admit that the greatest proportion of my personal attention is on those seniors and disabled individuals. I have great staff who really oversee the managed care program. But because of the span aspect, my role personally is what we can do better for our seniors and disabled individuals in our fee for service structure.

In absolute numbers that make sense that our children would be covered in managed care arrangements, they make up about 60-percent of our total program participants. And like many states, we pay for more births than any other payer.

As you can see in Missouri, we are statutorily prohibited from enrolling those seniors and the disabled. That's been an ongoing and quite intense I'll call it a conversation over the four years that I've been in the state. The hospital association and the mental health advocates fiercely opposed to expansion of managed care to this group. And thus far there's not been any traction in the legislator.

So we're mandated to provide managed care for that traditional tan of population in the central counties of the state. And there you can sort of see the geographic distribution between Kansas City to the west in Saint Louis, home of the Cardinals [laughter] to the east. So you might get the idea and it's true as we think about our delivery system, managed care is predominantly an urban delivery system. And for the rest of our population in those flight counties, that's a very, very rural area. Not a lot of providers and frankly, not a lot of people in a lot of those counties. So the intensity of the focus is really there in the central region.

This slide's a little dated now but it's still pretty much still pretty accurate. Missouri because of that statutory

prohibition is just shy of 50-percent in terms of our total lives covered in managed care. And I don't really see that needle moving a lot before 2014. But as we look ahead to how Medicaid will integrate into an insurance exchange, whether that be state level or national, that decision's not been made yet. I think that consideration around the engagement of Medicaid patients in the exchange, whether that be through managed care plans or other arrangement, is going to be a fascinating aspect of my job looking ahead.

So with all that said; what's the big finish question? The answer from Missouri has managed care been a good deal over the years since 1995 or not? Is it good for patients? And my answer, I'll be very honest, is an unqualified yes, it's been a good deal for Missouri but the number of caveats and assurances. And we'll get into those in a second. We have enormous problems in our fee for service population with access.

I spend a lot of time giving talks around the state and trying to convince physicians in the out state to accept Medicaid patients. And it's an enormous struggle. We pay 62-percent of the Medicare rate on our fee for service side. And so we have way too many children in the out state having to be transferred to Saint Louis and Kansas City because no

orthopedist will accept them in the boot heel of the southeast of the state.

That never happens in manage – well I shouldn't say never. It virtually never happens in managed care. I do not get those phone calls from my managed care patients. And so to me, the real huge value added of managed care as a physician and advocate is you can actually access and you can hold the plan accountable for those services including specialists which is, of course, the toughest access point for Medicaid patients.

So, we also have appointment standards for post-hospitalization, for standard appointments, for urgent care. We track that, monitor it. We track member satisfaction in our managed care patients. And I'm pleased to say that our rates for this past year were all above the NCQA national average. I'm not funded to track that in fee for service and I'm embarrassed to say I don't even know the satisfaction on my fee for service side. But I know in managed care, in general, our patients are very happy and very pleased with their level of service.

One of the fun parts of my job is thinking about how to demand and drive to improve quality in our program. When I first got to Missouri in '07, none of our plans and we have six by the way that we've been contracted with for some time were NCQA certified. And none of them really seemed to care about

that. So we wrote it into the contract and said if you don't reach that accreditation by October of 2011, you're out of business in the State of Missouri. And now they're all accredited. Every one of them came in this year; I'm very pleased to say.

We put a lot of time into assuring that case management for high needs individuals that you'll from Mary here in a minute is attended to. And we follow the HEDIS measures very carefully to demand increased quality year over year and that these populations are being served. And it's frankly an appealing aspect of my job to be able to explain to the legislature and to the governor's staff the value added that managed care brings over our core program.

You can't really have a discussion about managed care in this budget environment without getting to the costs. My staff reminds me I'm better talking about the people than the services than the numbers. I agree with them. But overall, about a billion dollar of our $8.5 million global budget of the Medicaid budget goes to managed care. We commissioned an external evaluation in 2009. And it did demonstrate in this mature program about a $38 million savings compared to the fee for service structure. So we were quite pleased that we actually – as we've been promising CMS for all these years that we actually did save money in the program.

There are clearly concerns with managed care. I don't want to sound like an unabashed, 100-percent advocate. You have to hold the plans accountable. If you don't like tight contracts and have enough staffing to assure that the performance measures are being met, really monitoring and basing on your data then you will be taken advantage of.

If you just write a contract and look at it again three years later what's going on, it's a big mistake. And for many years in the early years of managed care, frankly Missouri did not have the staffing. And we did not have the expertise. And I've been very fortunate that the governor and the legislature have been helpful in providing staff and to help us assure that compliance.

So what are we buying? As Vern referenced very well, I think, we're buying accountability. I have one neck to choke and I know the [laughter] on speed dial the medical director and the CEO of every one of our plans if there's a problem with their participants. We like the predictability of the budgeting. We like it that we've demonstrated cost effectiveness to the delivery system. We believe we're doing a better job. We've still got a long way to go but we think we're doing a better job on the value proportion. And we're going to continue to compliance monitor very carefully. With that, thank you very much.

DEANNA OKRENT: Well thanks so much, Ian. It was good to hear all about Missouri and what you folks are doing there. But now that we've heard Missouri's story and how often have we heard if you've heard about one state's managed care program or whatever, you've heard about one state's program. So we're going to turn to Matt Salo to tell us what some other states are doing.

Matt is the first executive director of the National Association of Medicaid Directors. You might have thought this organization's been around for a while but this is a new iteration with a slightly new name and definitely a new executive director. The organization was formed in February 2011. And Matt tells us that was a bit of homecoming for him as his first real job out of college was working for the Medicaid directors from 1994 to 1999.

And many of you might know Matt from the 12 years he spent at the National Governors Association. You say that's where I know the name from. [Laughter] And there he worked on the governor's healthcare and human services reform agendas and on modernizing the Medicaid program. Matt can tell us just about what every state is doing in their Medicaid programs. But I suspect he's going to highlight just a few here today to bring us a varied and interesting story of what's going on across the country. Matt.

MATT SALO: Okay. Thank you. And, thanks to the Alliance for putting this together. I've been doing health policy in this town for pretty close to 20 years now. And the Alliance has always been putting on really, really fantastic, solid presentations and convenings which have been enormously helpful to myself and to a lot of other people. So thanks for all the good work that you do and the lunches that you provide. [Laughter] It's nice. Well –

So yes, I'm – I get the pleasure of following both Vern and Ian so I get to stand on the shoulders of giants. And I'm not going to do a PowerPoint. So unfortunately you're forced to stare at us. But I do that partially because this way any time there are reporters in the room I can just say well I was clearly misquoted [laughter] because I have plausible deniability without any PowerPoint.

But I think I want to build on what Dr. McCaslin was saying and talk a little bit about what's happening in the other states. And while their exact circumstances may be different, in a number of different ways the underlying motivating factors, I think, are largely the same. And I think there are – you know I can't walk out of here without leaving you with two main points. And these are the two things that are really driving state Medicaid programs at this point in our nation's history.

And they really are one, the imperative to find budgetary savings. And I'll get into that a little bit more. And two, the imperative to do a better job of managing people's healthcare, of driving improved healthcare outcomes and in trying to fix, quite frankly, what is in many ways a failing or broken healthcare system in this country.

So two broad imperatives that states are facing; saving money, improving care. In many ways the answers to both of those can be the same but not always. And I think that is one of the challenges that it's important to always keep in mind that whatever states are trying to do, they are trying to improve care.

You know Dr. McCaslin talked about his desire to cover every kid in the state perhaps the country. And I think, you know, Medicaid directors are clearly joined by a vision of trying to provide the best possible healthcare to the most number of people within often very, very difficult budgetary constraints. So while they're trying to improve care, the thing that really drives it. If there's a conflict, the thing that's going to drive decisions at the end of the day are budgetary decisions. Because state government, unlike the federal side, states have to balance their budgets.

And so as states going into their current fiscal year which generally starts around July 1, they were facing $175

billion cumulative budget shortfall. And they've got essentially a two year window over that biennium to close it. So a lot of states you can see and we'll – you know I'll talk about this in a second, you know moving more into managed care.

And I'm going to use the phrase managed care very broadly because it includes turning the processes over to a Centene or you know to someone else to manage the care. Or if a state has the capacity, it can bring that management back in-house. You know trying to do the oversight, trying to do the care coordination, trying to drive the delivery system and the payment reforms in-house at the state level.

Now the challenge is that there are a lot of states who seem to actually be moving away from managed care. You know states like a Connecticut or a Massachusetts or states that are not going to do it for a variety or reasons like Missouri. A lot of those states have the capacity to drive significant, broad health system reforms. Not all states do. And with most states facing significant workforce reductions because of budget cuts, we have states that are – have 40-percent reduction in their state government workforce in the past five or six years.

This lays out enormous challenges. But at the end of the day, there is no question. There is no question that the key to both solving long run budgetary challenges and trying to

bend the cost curve on healthcare in this country and trying to improve what I think are arguably very disappointing healthcare outcomes in this country, it is moving away from the wild, wild west of the unregulated, unmanaged, uncoordinated fee for service system.

And I think the mentality which sometimes is hard to die off that the greatest good in our healthcare system is the unrestrained ability to go see any physician or any provider at any time for any reason has failed. That is not a sustainable philosophy both in terms of cost and in terms of actual healthcare outcomes.

So states are and as Vern pointed out and Ian pointed out, there's a lot of managed care. Managed care defined differently in state Medicaid programs but not where the money is. Whether that's the dual eligibles or whether that's other individuals with disabilities or chronic care conditions and that's the direction that states are going and they're going to have to go. Because those folks are expensive in part because they are sicker but in part because the healthcare system an unregulated, uncoordinated fee for service system is not serving their health needs well.

So states are going to move in that direction. And in some cases, it will be through an MCO. In some cases, it'll be through PCCM. In other cases, it will be states trying to

figure out something else. Managing care through a health home, managing care through some kind of – I don't want to say an ACO because that has it's own kind of connotations but some kind of entity that is accountable that has, as Ian says, a neck you can go ring when things go wrong because that really is the challenge here.

At the end of the day, there's a lot of dysfunctional incentives in the current healthcare system. And we shouldn't be surprised that when we provide – when the U.S. healthcare system and Medicaid's a reflection of that and Medicare is a reflection of that. But when in the U.S. healthcare system, we provide financial incentives for people to get multiple redundant CAT scans. When we provide financial incentives for people to use the ER as their primary source of healthcare and when we provide incentives for individuals to get re-hospitalized for no good reason, we shouldn't be surprised that that's what we're getting.

And that's what we are – that's what we have to stop. And that's really what states are looking to do using Medicaid to drive that. Is the Medicaid the best driver of this? No. It is a part of the system. But I think arguably Medicaid is the program that is under the most urgent budgetary constraints. And it is those kinds of urgencies that will drive action.

So I'm actually fairly excited because I usually do this speech in like 30 minutes and it's really depressing because I talk about all the problems. And I try to end with kind of a silver lining that the solution is within our grasp. The solution is trying to manage the care and coordinate the care for those where that is not happening at all. And that will drive lower costs and that will drive better healthcare outcomes. And I think that is what we all want at the end of the day. So I'll stop there and look forward to questions.

DEANNA OKRENT: Alright. Well thank you so much Matt. Let me now turn to Dr. Mary Mason, our next speaker, who serves as the chief medical officer and senior vice president for Centene Corporation. We've already told you a little bit about it. It's the healthcare enterprise that provides programs and services to underinsured and uninsured individuals. Many of whom are covered under the Medicaid program.

Dr. Mason is a board certified internist. She also has a degree in bioengineering to show you other parts of her personality and an MBA. And she has been a panelist on an Alliance program before. Dr. Mason will tell us about some of the programs she has created to improve quality outcomes in a patient population with significant health issues.

You may know that Centene is headquartered in Saint Louis. And so I guess Dr. Mason is the second of our

presenters [laughter] who found it important enough to leave the excitement of the World Series and be with us today. So Mary, welcome back to an Alliance panel and thanks very much for being with us. And thanks to Centene for being part of the program.

MARY MASON: Thank you so much. It's really a great pleasure to be here. Last night my husband said, "You should say something about the Cardinals tomorrow". And you know what; I don't have to so [laughter] thank you both.

So, as Deanna said, Centene specializes in the underinsured and the uninsured. Most who are uncovered under managed Medicaid. We are currently in 14 states. And we have approximately 1.6 million members.

Initially we started out in TANFs, CHIPS so moms and babies. But over the years, we've continued to expand into adults with the aged, blind and disabled. And foster care has really been a very unique and great product for us especially bringing in our expertise from our behavioral health company as well as long term care. And as you can see, 72-percent of our members are under the age of 18.

So one of the things that I'd like to do today is kind of take you from a clinical perspective of how do you create clinical value when you're creating clinical programs under managed Medicaid. And as you can see from our diverse mix, we

have to be experts in a variety of diseases and also prevention. So pregnancy, prevention of NICU babies is so critical for us as well as asthma, diabetes both for adults and children, cardiac disease, mental health such as depression, ADHD, sickle cell disease. And also making sure that we have prevention and that we're being very proactive in reaching out to make sure that our patients get the preventive services that they need.

One of the things that I like to do is kind of put these disease states on a spectrum. Because you have to be good at all the disease states not just the ones that are very prevalent. So while you can be – you have to spend attention on immunizations, pregnancy because we have so many patients who have those needs.

You also have to be able to focus in on those rare diseases so such as hemophilia, the Gaucher's disease, those patients that really drive costs. So when though you may have only 30 hemophiliacs versus 70,000 pregnant women, you need to still be able to focus in and give that very specialized attention to those 30s. And often you can see the same amount of cost savings and rewards.

So I want to take you through how we design clinical programs at Centene. And it all starts with what we call CENT Intelligence. And this is our predictive modeling system, our

specialized IT programs where we are able to take patients, look at claims' history, look at information that we get from our health risk assessments, pharmacy data, any information that may be coming in from the eligibility files. And we can zoom in and tell who are the sickest of the sick, who are the ones are going to most likely be admitted to the hospital and need our attention immediately.

And this has been very critical in our pregnancy programs especially when you have a very short window when you need to get women into your programs especially when they're coming on at 20 weeks or even 30 weeks gestation. So really CENT Intelligence is so key to us. It also helps us to identify high quality doctors who are also providing low cost care as well as quality gaps. We can tell if a patient needs their mammogram or did they need a pap smear or their immunizations. And all of that is so important especially when you're trying to figure out who do you take your resources and where do you concentrate them.

We then, once we develop a strategy and we use evidence based medicine. We use sound clinical policies, physician experts, to make sure that we are doing the right thing by the patient. We then are able to use several different tools to design our clinical programs. One of the things that we've been able to use is our CENT Account. And this is a debit card

where the patient basically gets money put on their card when they do preventive healthcare.

So if they go to their prenatal visit, they get dollars on their card. And then they're able to use those for health related items. We also align that with our fee for performance which is able then to have the doctors' incentives for seeing that patient, that prenatal visit, also aligned when the patient goes to the prenatal visit. So it's very, very effective.

We also have very strong case management, disease management and care coordination. And I can not stress the importance of this in this population because if the patient doesn't have a ride to the doctor, they're not going to go. So you can not miss – you can not forget about in this population. And also our free cell phone program where we give preprogrammed cell phones to our high risk patients who don't have safe reliable access to a phone.

So let's concentrate on pregnancy. Start Smart for Your Baby is our comprehensive prenatal post-partum program. One of the key things about this program is it starts at pregnancy but it follows the child through the first two years of life. And we designed it this way because so many women lose their eligibility six weeks, eight weeks post-partum yet the child is still on our plan.

So we use that time during pregnancy to develop a very strong relationship with that mother in order to influence the care that she is giving to that child in making sure that she has taken her child for preventive visits during those first critical years.

What we also do is have an early identification system called Notification of Pregnancy. And we call this our ticket into the program. And one of the things that's been so key about this and this is a multi-varied analysis of 38,000 women who had a Notification of Pregnancy coming into our program and we compared it to a control group.

And what we found if they had that ticket into the program which had some very streamline risk factors that we could put through our CENT Intelligence, we had – when you look at the less than thousand gram babies, these are the most – these are the million dollar babies. The ones that we hear about in the NICU for weeks and weeks and weeks, 31-percent less if they had an NOP verses not having that notification of pregnancy. And then if you looked at the 1,500, 20-percent fewer. And then even in the ones that less than 2,500 grams, 8-percent. So this is – really shows the cost savings here.

And then you can also see here on the right how our HETUS numbers have continued to increase in the program as well. So here we were able to save $14 million overall of

course, across 70,000 women in our program at the cost of $75 per pregnancy. So this has really been a great success story.

RSV or Respiratory Syncytial Virus, another very important issue for us, one of the number one causes of children being admitted to the hospital under the age of one. We have a very comprehensive program with Synagis which is an injection used for immunoprophylaxis for RSV. And once again stressing compliance, dose management and also preventive measures such as don't smoke in the room around the baby, wash your hands. We've really been able to save over $8 million especially by following guidelines from the American Academy of Pediatrics making sure we're getting the right candidates for this medication.

Another example is hemophilia. Once again, we don't have a huge number of hemophiliacs; 64 across 1.6 million members. But by really paying close attention to the details, early identification of these members using their hands on approach with case management, disease management, care coordination, 96-percent compliance with the fact – or I'm sorry. What we are able to do is show that with assay management we are able to save over a million dollars just by making sure they're getting their dose and they're staying compliant.

Sickle cell, another very important disease state for Medicaid. Once again being able to concentrate on the 1,500 plus members in our current population, making sure that if they are candidates getting them medication called Hydroxyurea to make sure that they can help prevent sickle cell crisis, keep them out of the hospital in those painful crisis that sends them to the emergency room. Once again, using our information technology, our CENT Intelligence, being able to identify those people who are not taking the medication who need it, we are able to design a program that helps to drive down ER utilization and in-patient admissions.

So in summary, just the observations overall when developing our clinical programs, I can not stress prevention. In order for managed Medicaid to work, you have to get the patient to the medical home, get them the services they need and often you have to be there nudging them along the way incentivizing them either with the CENT Account, calling them reminding them this is what they need.

And also I will say coverage is another very important thing we need to look at especially with pregnancy. When those moms lose that insurance after they deliver and they still have the baby, what can we do to keep them on Medicaid as well as how do we get moms onto Medicaid sooner. As far as when

they're pregnant, it's so much easier to deal with a woman who is 15 weeks gestation verses 30 weeks. Thank you very much.

DEANNA OKRENT: Well thank you Mary. Finally speaking of quality care and health outcomes or special populations as Mary was describing, we're going to hear from Judy Feder, a familiar voice around here and a nationally known analyst. Judy has appeared on Alliance panels before and we're happy to have her here again.

JUDY FEDER: Thank you.

DEANNA OKRENT: She's a professor of Public Policy and has served as dean of the Georgetown Public Policy Institute. In addition to being a scholar, Judy has served as a health policy leader promoting effective health reform as staff director of the Congressional Pepper Commission in 1989-90 and as principal deputy assistant secretary for planning evaluation at HHS under President Clinton.

She's a member of the IOM, the National Academy of Public Administration and the National Academy of Social Insurance. And she serves on a number of boards. Bringing us a wealth of expertise on Medicaid issues and financing of public programs, I give you Judy Feder.

JUDY FEDER: Thank you Deanna. And my charge today, will you figure this out for me?

MATT SALO: I will.

JUDY FEDER: Okay.

MATT SALO: I got it. [Laughter].

JUDY FEDER: Alright so and so I can pay attention to my charge today which was that you heard at the offset Deanna said that I'm on this panel to give a cautionary note and I – that's not a very happy task. We have all this enthusiasm and good news and World Series. It's all – so and, I think what we've heard particularly when you listen to Mary describe what good managed care can be, it's a – there's – it's a wonderful thing.

So my cautionary note to us today is basically on a concern that our enthusiasm might get out of hand. And that comes from what – Matt not yet. We're not out of hand yet.

MATT SALO: Oh. Sorry.

JUDY FEDER: I'll let you know.

MATT SALO: I got out of hand. [Laughter].

JUDY FEDER: You got out of hand. That's right. That's right.

MATT SALO: It happens.

JUDY FEDER: So, the concern is – it comes – Matt said it himself that the concern is that budgets are driving the process. And I'm not going to talk about managed care for everybody today. What I want to talk about are the dual eligible population, the population, the 9 million people, who

are eligible for both or enrolled in both Medicare and Medicaid.

They are all poor or have become poor because they need long-term services and supports. And they are disproportionately cognitively impaired, a lot of mental health problems in this population, a lot of long-term care needs. On the other hand, there are some people who just old and poor. So a tremendously varied population but also a tremendously costly population. They account for about 40-percent of the spending in both — in each Medicare and Medicaid.

And so as we said, we're talking about them because that's where the money is. Not the best way to be promoting to better care. And the concern is that our budget pressure might lead policy makers to push past all the innovation is going on whether it's innovation at the state level or innovation in the new innovation center and office for dual eligibles at CMS.

But push past that innovation to actually assume that by limiting dollars and assigning somebody, whether it's a state or a managed care organization, to be responsible. We can assume saving are going to exist and just take them and give somebody else responsibility for the dollars. And I would say that's something we really ought to be quite cautious about. Some of the reasons we've already heard.

Now we can go to the next slide. Our speakers have emphasized that are experienced with managed care for dual eligibles is really quite limited. That in part because law does not allow the states to require managed care for Medicare beneficiaries and dual eligibles are Medicare beneficiaries. And in part because states and plans have been focusing on the moms and kids population to build their experience, we just don't have a lot of experience with the kinds of conditions and the kinds of populations that are represented among dual eligibles. Mary's given us an indication of potential there but that – realizing that potential is a challenge.

Now they're – we've been focusing on Medicaid managed care but there is also, as we know, managed care in the Medicare program. In fact in addition to Medicare Advantage plans or among Medicare managed – Medicare Advantage plans are a set of specifically targeted plans mostly for dual eligibles that are special needs plans. They're called that. But our – we have about a million people in those plans so still not by no means all dual eligibles – 9 million dual eligibles.

And the – our information on these plans, as MedPac reports, is really quite limited. We don't know very much about what's going on in them. As some have said, we don't really know what makes them special. Although they are pursuing – supposed to be pursuing some kinds of coordination,

we don't have much information on what's going on in those plans. And we don't have information or accountability for the kinds of measures that matter in terms of getting the better health we're talking about like the hospital admission or re-admission rates or emergency room use or medication errors, what have you, with respect to making sure that these plans are getting – are actually giving better care.

So that's the first caution; not much experience. A second caution is that things that are called managed care plans or managed care may not really manage care. Our columnists are finding that where we see savings from managed care plans, whether private insurance or Medicaid, a lot of that reflects the lower payments by these plans to providers even in Medicaid which may surprise some of us. It did me. Rather than more appropriately or more efficiently delivered care. So it's not necessarily the kind of management that Mary described that we might be seeing.

I think we're all well aware that Medicare's reliance on managed care actually increased rather than decreased program costs leading to the changes that were made in significant savings in the Affordable Care Act with respect to way Medicare Advantage plans are paid.

And Mary knows far better than I how intensive their coordination has to be to really be management. She really

gave us a good sense of it. Whether it's the IT that enables the providers of care to know what's going on with their patients, the care coordinators and their relationships with doctors and with families, real time information about what's happening to people and what their particular needs and circumstances are. It's a big deal. And so we can't simply assume that it's going to exist by limiting dollars and hope that it arises.

Now when it comes to dual eligibles, thank you, and the heading on this slide is really – it should include dual eligibles because what – that's what I'm talking about. The kinds of coordinated care that we're discussing here is really the focus of the cost containment strategy in the Affordable Care Act. Whether it's accountable care organizations, medical homes, health homes, a bundling, a host of measures that the largely led by the innovation center, it aims at promoting the kind of care management and care coordination that Mary described. And a primary target of that innovation or of that coordination is to reduce unnecessary hospital use which is really where the big bucks are in terms of producing savings in the system and better quality care.

And dual eligibles experience what – and preventable admissions at a far higher rate than other Medicare beneficiaries. And so are appropriately an important focus for

measures to better coordinate their care. But it's Medicare not Medicaid that pays for virtually all of dual eligibles hospital care, indeed all their acute care. Not counting what Medicaid pays for Part B premiums for dual eligibles.

77-percent, more than three quarters, of Medicaid spending for dual eligibles goes to long-term services and supports which are received by fewer than a third of Medicaid beneficiaries. So remember that great diversity and note that the acute care that we're talking about coordinating for dual eligibles is really all paid for by Medicare. Dual eligibles remember are Medicare beneficiaries.

And you can see the fiscal consequences. There's some budgetary consequences of this when you compare the federal spending on dual eligibles to the state spending on dual eligibles. The facts are that the federal government finances 80-percent of spending on dual eligibles. Two thirds of that is flowing through the Medicare program. And the rest is Medicare – is the federal share of Medicaid. So Medicaid accounts for – it's significant to the states. And don't discount it but when you look at the responsibility for whose really responsible for this population, Medicaid pays for only about 20-percent of dual eligibles' care.

And that takes me to my next point and hopefully my next slide which is why [laughter] dual eligibles – thank you Matt – are primarily –

MATT SALO: I'm not getting paid enough for this. [Laughter]

JUDY FEDER: It's so true.

MATT SALO: Yes.

JUDY FEDER: Are primarily a federal responsibility. There is an enthusiasm right now and I talked about it at the outset. An enthusiasm from, as I said, blowing past the innovation and requiring dual eligibles to be in managed – in some kind of managed care arrangement whether through a plan or by giving the monies to the states to manage. And the – in order to make that score in a budgetary sense to actually guarantee savings, there's also enthusiasm for well look what we can do with these services. So let's just assume we cut the costs up front and provide less money.

Now I am a strong believer that states should partner with Medicare to better coordinate services for dual eligibles especially for the long-term services and supports that it's a portion of this population requires. And that state does – is responsible for. And that states could share in the savings that result.

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But if we get a little too enthusiastic for those savings and allow states to benefit from them without sufficient constraints, there are serious risks. There are risks to – fiscal risks to the federal treasury because we have a long history and understandable that strapped states looking for federal dollars are likely to have them replace state dollars rather than add to the overall supports that are going to the population.

And we're not looking here for a state – for fiscal relief for the states. We're looking – although I'm for that. I'm really for that, Matt, [laughter] but not in this fashion. So it is we're looking for getting better care. So we've got to be really mindful of that effort that it not become a piggy bank for strapped states.

Secondly, dual eligibles, as Medicare beneficiaries, need a lot of protections. They're very vulnerable. And they get some of those protections through Medicare that are at risk if responsibility for that population is turned over to states. And they are actually transformed no longer into dual eligibles but not longer Medicare beneficiaries but become Medicaid beneficiaries. So, and of course, they're at risk if in fact those dollars are used to achieve savings rather than more efficiently deliver care. And they are actually in a more vulnerable not a more beneficial place.

So if you – if I've shifted your head a little bit to thinking about how – it's right there – how Medicare can take the lead, I'll just give you a couple of examples. First Medicare needs to aggressively oversee and hold accountable its managed care plans for dual eligibles. It doesn't do that right now. It needs to do it.

Second, we need to see an emphasis on dual eligibles especially those using long-term supports and services in the innovations that we're seeing from the innovation center from Medicare. The – it is – we hear a lot of concern appropriately about the costs of people with chronic illness. Well when we look at the data and we – I have a site for you there to – a recent analysis I did with Harriet Komisar.

When you look at the data, the problem is not chronic conditions. The problem is people whose chronic conditions create not only needs for costly medical care but also needs for long-term services and supports. That's the population we need to be focusing on in particular that half of them are dual eligibles and a half are not.

And finally, I call attention to one of the biggest issues that is – of cost shifting that goes on between Medicaid and Medicare that is a concern when we talk about dual eligibles. And that is the behavior in nursing homes of admitting patients to hospitals when those hospitalizations

could have been prevented with good nursing care in the nursing home. Admitting them to hospitals, driving up Medicare costs in the hospital and doing God knows what to the beneficiary – the nursing home resident and then taking them back into the nursing home at Medicare skilled nursing facility rates which are higher than the rates that Medicaid pays. This is pretty inexcusable. And it is Medicare's job to stop it by holding skilled nursing facilities accountable for excessive and preventable admissions to hospitals.

So I'm calling for Medicare leadership because dual eligibles are Medicare beneficiaries because the federal government pays 80-percent of the costs for dual eligibles. And none of that is meant to eliminate the importance of state Medicaid initiatives whether for the general population or for this population where they can come together. That's an important and valued thing to do. And where states invest in care improvements that provide savings, sharing those savings with Medicare is appropriate and desirable.

But again, states pay for only 20-percent of the care for dual eligibles. Very little of it goes to acute care where the savings and quality improvement are most readily achievable. Achieving these savings is Medicare's job. And we ought to be looking to Medicare to pursue it. Thanks.

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DEANNA OKRENT: Well thank you Judy. And you've all been very patient listeners. We've had a very full panel here for you today. We've fed you a lot of information and now it's your turn to come to the microphone. There are two on the floor. I know the room is a little tight. It might be hard for you to get to one. But if you want to make sure your question gets asked and you get an answer from the panel that would be the best way to do it.

If that's problematic, there are folks going around the room to collect your green cards on which you can write out your questions. And hopefully we'll be able to get to those as well.

Well I was going to start with a question to the panelists but looks like we already have some with a – someone at the microphone. So, I will go straight to the floor.

TONY HOUSNER: Hi. Tony Housner. I'm an independent consultant formerly with CMS. And I certainly agree with Judy that we need to figure out some reforms for dual eligibles. Judy has suggested the burden be on Medicare. I'm interested in a variety of thoughts. My concern would be one, we need to integrate the payment systems between Medicare and Medicaid, integrate the delivery systems and ensure that the – integrate the quality of care measures as well. So I'm interested in the panel's thoughts on what we can do. I think I'm hearing Judy

say put that on Medicare and have her confirm that but also hear from the panel members your thoughts about that because you may have different thoughts.

MATT SALO: I'll be happy to start this one off. And I'm sure other people will have thoughts.

TONY HOUSNER: And this was for particularly the dual eligibles I was talking about.

MATT SALO: Yes. I was encouraged to see that Judy's remarks today were a little bit more welcoming of state participation in this process than in the actual report that came out.

JUDY FEDER: I read from it. I read from it.

MATT SALO: I read the report too.

JUDY FEDER: And said the right things. [Laughter].

MATT SALO: I think two things about this. One is that most of that sentiment is right that yes, by God, Medicare should be caring about this population a little bit more than it does and doing a little bit more to try to improve their care. But quite frankly, that's stuff that we've been saying for 20 years.

Where has Medicare been? In la la land. And care has deteriorated. And the only people who have been trying to improve the care for this population have been the states. And they have been trying to drag Medicare along with them for

decades and not getting a whole lot of help with it. So yes, Medicare should. But I got to tell you if we're going to sit around and wait for Medicare to come to its senses and fix this problem, I think we're all going to die of old age in that waiting room.

And you know to sort of the – you know to sort of say oh yes, well you know states are going to use this as a piggyback – as a piggy bank but if states find savings, they should share them with Medicare. You know I don't know that's terribly helpful either. And at the end of the day, I think the last thing we want to be doing up here is defending the status quo for this population because the status quo is not helping them. And we need to do more. And we need to do more in an aggressive way.

And, just one final point, to sort of you know we can't – we simply can not stick our heads in the sand and say we should do all things based on good policy because you can't hope this budget problem away. It is here. It is real. And it is going to impact all of us. And are some decisions going to get made on behalf of that? Yes, they are. But you can't make that go away. So, end of soapbox. Ian.

IAN MCCASLIN: We're right there with you, Matt. [Laughter] Here we go. Here's one state. I would echo many of the considerations. I totally agree that the duals are our

most challenging population, our least in many respects served population. And it has been around and around and around for far too long.

I do think there's some good news though. And there's some good news specific in Missouri that I can share that I think will be also some good news from other states over the coming months. Section 2703 of the Affordable Care Act building health homes for individuals with chronic conditions was announced with the detail well over a year now. And when we first got the language, we were very disappointed that we could not exclude duals from that initiative. We were mad that we couldn't exclude duals because it – the same old story, state makes the investment, Medicare reaps all the savings. There's no sharing the savings. Gosh, there it's another example.

But as we got more and more into it, looked at the population, looked at the invention, it's a very health home model to be briefed, it was just approved by CMS. We were the first state approved in the nation. Under Section 2703, it's develop health homes for individuals with chronic, persistent mental illness seen through the community mental health centers in the state. It's about 15,000 individuals we estimate. In total, about half of those are duals. There's a 90-percent

federal match on the investment which we're very appreciative of. And we're going to stand very significant interventions.

As Mary I think really referenced, you have to own that population. You have to take full from the house to get them to transportation, pill counts, social supports as you pay in your heating bills. You know it's not just oh yes; you were in the ED last night. Let's see if we can get you straightened out. Yes, you've got to own those patients.

So the funding really is more than adequate. We were approved to per member per month payment by CMS. More than adequate, we believe, to really make a difference in those people's lives.

And so to get to the Medicare point, two pieces of good news. We're not there yet. We're – in fact we're far from it. But we've had some very substantial technical conversations with CMS about how technically we can share. We need the A, B and D data. Not having Medicare Part D data's a huge hole in our case management armamentarium. And while I don't have the details of the technical piece down, my understanding is we're making good progress.

And the second piece where I have been much more involved is in terms of a shared discussion with Medicare on shared savings for those Medicare – the Medicare savings. And obviously I want savings back for the state but what I really

want is to take a proportion of that savings and put it right back into the community mental health center. [Interposing] So they can even more deliver the goods so to speak.

So, I think a lot of states are looking at our language. For those that are interested, it's referenced on the Missouri Department Mental Health website. There's a dial of the medical homes. And you can see our state plan amendment and much of the background to it. But it has been, I think, a very productive conversation with Medicare. And we're looking for great things out of this program.

AL GUIDO: Yes. Hi. My name is Al Guido. And I actually represent the Community Mental Health Centers, Dr. McCaslin. We serve about 6 million people a year. About 2 million are dually eligible individuals with severe and persistent mental illnesses.

And I just wanted to sort of take – I wanted to follow up on the last conversation about the duals and ask another question in conjunction with that. And maybe take it out of the abstract a little bit and sort of home it in proposals that are floating before the Super Committee as we speak now.

I've seen at least one proposal from a major for profit insurance company that and I'm going to simplify this just to get the reaction of the panel that would create a new state option – a new state Medicaid option that would require duals –

that would permit the state to require duals to be enrolled in a managed care arrangements with an opt out. Now in this particular proposal, if the recipient opted out of the managed care arrangement that person would lose Medicaid eligibility completely.

And I'm not – it's just one proposal. I'm sure that there are many that are floating around that can be – I'm just hoping to get a reaction from the panel about sort of that specific widely discussed broader concept. And I'll sit down and take the response.

MATT SALO: I would say broadly not getting into the you lose your Medicaid if you don't because I think that's probably a little extreme. And I don't think that would survive anyway. I do think that starting to look at this arrangement with options like mandatory enrollment with an opt out are absolutely the right direction to go. Absolutely.

JUDY FEDER: So opt out, I think that the general interest in opting out is because people are not looking as carefully at it and are more willing to do things they might not otherwise do. If you have them opt in, it's a more passive process. But I would call to your attention that 61-percent of dual eligibles are cognitively impaired. I'd worry about an opt out in that circumstance.

MATT SALO: But does that mean that we're essentially saying the 60-percent of duals who are cognitively impaired, they're doing just fine managing the fee for service on their own?

JUDY FEDER: I didn't see – Matt, I never said that.

MATT SALO: I mean –

JUDY FEDER: I never said that. In fact the issue is it is it's a move to mandatory. That's a move to mandatory. And the questions that I think need to be asked, as been said, is that there's tremendously – there's very limited experience with this population and tremendously varied capacity. So in our desire to make savings which include – we should not simply requiring – I don't know that CBO would score a great deal for just requiring mandatory managed care if there's – it's requiring and capping dollars. As you go forward, that's betting the farm on an as yet untried experience.

DEANNA OKRENT: And I'm just going to jump in and put in a plug for an upcoming briefing where we'll have an opportunity [laughter] we'll have an opportunity to discuss the recommendations of the Super Committee or the possible recommendations of the Super Committee particularly on Medicaid. That briefing is coming up on November 10th. I'm not sure of the room but you'll all get an announcement. It will be on the Senate side I believe in one of the hearing

rooms. So remember November 10th for a deficit reduction and Medicaid. And you can continue this conversation there. But I think Dr. Mason.

MARY MASON: Well the one thing I will say is that when you do look at this population, I think it's important to look at the lessons learned around aged, blind and disabled. Because I do think especially as an internist, these are very similar populations.

So what works in ABD especially when you look at the population, 40-percent have a mental health illness in addition to their medical diagnosis. What works is co-locating behavioral health case managers with medical case managers, integrated care plans, working with the physicians and having that team concept, having a pharmacist. And we do that in our Ohio market with aged, blind and disabled having a pharmacist sit with the doctors and nurses and really working, as she said, the pill count.

And so the principles do work and when you think about it, it's just a matter of making sure it's coordinated and not forgetting about that behavioral health piece.

CAROLINE POPLIN: I'm Dr. Caroline Poplin. I'm a general – a board certified general internist and an attorney. And I was very pleased to hear of some skepticism about managed care with the elderly population which those were my patients.

I think the flip side is that there are tremendous opportunities for saving money on this side.

Managed care has a lot to prove because it adds costs at the beginning. All those layers of management and they have to save that amount of money plus additional amount of money. And I think there are other pressure points. CMS certainly has a whole office of nursing homes. There's a hospice program. There are lots of possibilities.

But the question I was going to ask is about Florida and Connecticut. If anybody knows what's going on in Florida. It just keeps sort of cropping up that they keep trying to push managed care and there's a lot of push back. It's not working. I was wondering if you knew about why Connecticut was backing away. And someone said something that PCCMs, the states are moving away from PCCMs and I was wondering why you thought that was.

MATT SALO: I know a little less about the Florida situation although I do know that they've had some back and forth or a lot of back and forth with CMS in terms of approving things and not approving things. And there's been some challenges that I think they've had with doing the proper amount of outreach as they try to expand more statewide. But that's that – I don't – that's about all I know about what's going on in Florida.

In Connecticut, I've actually heard what – I've heard it described as moving away from managed care but that's not exactly what they're doing. It's they're moving away from MCOs.

CAROLINE POPLIN: Okay.

MATT SALO: And what they're trying to do or what they've essentially found is that the experience of the MCOs in Medicaid in their state they've found that by and large they weren't getting the return on invest that they were hoping for with what they were paying them. And you know the additional oversight they were having to do wasn't worth it.

So as I said earlier, they're bringing the managed care more in-house and trying to apply those same principles just doing it with the state agency. And kind of like they sort of said, you know and this is kind of similar to what Massachusetts is doing for their healthier populations which is we don't need an external entity to manage risk.

CAROLINE POPLIN: Right.

MATT SALO: We can do that ourselves.

CAROLINE POPLIN: Right.

MATT SALO: And you know that's great. Not all states have the sophistication and the capacity given their workforce shortages to do that but that's, I think, basically what's going on there.

CAROLINE POPLIN: Thank you.

MATT SALO: Vern, any –

VERNON SMITH: No. Matt, you got it exactly right. And they did have some experience with risk based managed care in Connecticut. And it's a good example of what happens when the state exercises its oversight responsibilities and discovered that performance of the health plans wasn't up to the benchmark expectations particularly with respect to access.

And so in the course of making some adjustments, decided they do in Connecticut have a certain kind of expertise in health insurance in that state [laughter] and [interposing] so they're moving away from PCCM which never got off the ground in a successful way and away from MCOs. They're just going to run it themselves.

But in that, they will build in the requirements, the benchmarks, the standards, the quality improvement things. And so it's not really moving away from managed care. It's a different form.

CAROLINE POPLIN: Thank you.

KATHY KUHMERKER: Great. Hi. I'm Kathy Kuhmerker with the Association for Community Affiliated Plans which is a member organization of 59 safety net health plans across the nation in about 28 states. And while I am going to – just a brief comment on dual eligibles because we've been very, very

supportive as a managed care organization and as an organization that works in, let's say, with SNIPS for dual – for managed care for duals. And I think there are – this has been a fascinating discussion. Just wanted to say we're very supportive of very – of integrated planning for these individuals.

But I'm actually not going to ask a question about that. [Laughter] And I'll talk about it another time. So I really want to take us to a slightly different place and really back to managed care generally. And some of the real benefits that it provides, a real continuity of care and real quality of care. And one of the things that concerns us, as an organization and myself, as a former Medicaid director, is the fact that people lose their eligibility so frequently in the Medicaid program. We're very supportive of continuous eligibility.

But in addition to that, even if that were not to happen, we're also concerned that when people lose their eligibility that they churn very much around right at that break point of going into the exchange. And one of the alternatives to that, as we've been looking at, is the basic health plan. And I was really wondering if there were some comments that members of the panel might have about the possibility of the basic health plan particularly if maybe it

might be able to handle some of the issues of provider payments when you take a look at the dollars and cents that would apply.

MATT SALO: I'll take that one too. [laughter] I think the basic health plan is one of those things that looks great on paper. But when it comes time to actually making it happen, it's harder than it seems. It's harder than it looks. And I –

KATHY KUHMERKER: There's a lot undecided about it.

MATT SALO: Yes.

KATHY KUHMERKER: Definitely.

MATT SALO: And, I think that I – for a number of reasons that you're talking about, it may make sense if there was a basic health plan in existence to kind of facilitate some of that churn. But I think the reality is that given state budgets, given lack of state capacity, decimated workforce and the work it would take to create the basic health plan that most states, unless you're Washington essentially already has one, aren't going to create one unless it's really, really easy. And I don't know that creating one is really, really easy.

KATHY KUHMERKER: And do you think it could be similar to the essential health benefit package maybe? Sorry, I don't mean to be having a whole conversation here but –

MATT SALO: I mean I think the – I guess the essential health benefit's different kind of discussion.

KATHY KUHMERKER: Yes, it's different but —

MATT SALO: I don't know.

KATHY KUHMERKER: Okay.

MATT SALO: I don't want to hog the mic on basic health plan though.

IAN MCCASLIN: I think Kathy it's a good question. It's a fair — and I would say you know in theory it looks great and has the continuity. Don't worry about the churn. We have a standard benefit structure, presumably a uniform provider network. It's you get rid of a lot of twists and turnaround that 138-percent is very appealing.

I think in terms of the mechanics I couldn't agree more. I mean I — in the last three years, I've lost 20-percent of my staff. And I don't have people to think through the practical considerations with the state lens. I've got a number of very good consultants who are having a lot of fun helping us to think through it. They're having all the fun these days.

But in general, I think the timeframe, it's too short. We don't have enough time to really think through it thoughtfully. Where I would say with the qualifications still the decision's not been made of whether Missouri will have a state level exchange or what default of the national exchange.

The consideration around developing state level exchange is very strong on exactly this issue.

If we go out to the market and say 1.2 million Missourians will be on Medicaid, another 700,000 - 800,000 that look to be eligible for the exchange, that's enormous market leverage. If we can unify that population and use that to our advantage in contracting through a managed care route and say to the managed care plans, forget this Medicaid payment rate and network. And then a commercial rate and network, we're going to have some continuity here.

So a family who has seasonal work, income fluctuates, has one card, one doctor, one network, one set of benefits, some continuity and they're not flipping in and out back and forth every four to six months as we know they do. That's the path that we're really analyzing carefully of how we can influence the market to bring exactly that. Whether it would be Medicaid managed care plans that expand into the commercial, more likely the commercial plans will partner with Medicaid centric plans or there's some that are already capable, we think, in serving both ends of the spectrum.

But really to the extent possible that we can demand a value and continuity of provider network and some sort of stability in the rate structure, you know those goals of the basic health plan, we think, are very solid. But I don't think

that we believe – we completely agree with Matt that we have the capacity to stand that up in the timeframe.

DEANNA OKRENT: Well I'm going to take a couple questions from cards now. And we will get to the remaining questioners on the floor. I believe there's enough time. Although I'm reminded to remind you about the blue evaluation forms, we really do appreciate your filling them out. And for everyone who does fill one out and leaves it outside at the registration table, there is candy for you. So [laughter] a little reward for your efforts.

Two questioners –

MATT SALO: Is that sponsored by the dentists?

[Laughter]

DEANNA OKRENT: Right. We felt a little funny about it being a health related organization. But being so close to Halloween, we thought we'd go with the candy. [Laughter] Two questioners are interested in possibly better managing Medicaid drug costs. And I wonder if any of you want to chime in on that. One of the questioners talks about states being able to collect rebates from managed Medicaid prescription drugs. And, another one talks about how Medicaid drug dispensing fees seem to be more than twice that of Medicare Part D and the commercial markets. So I wonder if you can talk a little bit about that.

MARY MASON: Yes, I can take one on the drug rebates. This is referencing the DRE legislation about where it was actually states could get better rebates back from the pharmaceutical companies for the drugs verses an MCO which led some states to go ahead and carve out the pharmacy benefit.

The one thing that you'll find when you're managing especially these very difficult populations, the pharmacy piece is so critical. And when you think about your asthmatic, how do you keep an asthmatic in check with their symptoms? We get them on a maintenance medication if they have persistent asthma. And that keeps them out of the emergency room.

But if you don't have that real time pharmacy data because somebody else is – has the pharmacy benefit even though they're giving it to you in a week or a month, you can't quickly act on that when you see that a patient has not gone to the pharmacy to refill their medication.

So one thing that I think is important in this and now I think with the legislation more and more states are now carving the benefit back. I know that Ohio and Texas are two examples of states that are putting the pharmacy benefit back in under the MCOs. It really does make sense because what you want some – you want one entity managing the entire patient.

And also think about it from a HETUS standpoint, there's several measures with HETUS that are based on pharmacy

data. So that too then can, when you have different entities managing the benefits, it can actually decrease the quality.

VERNON SMITH: Yes, and maybe just to jump in on this. The pharmacy rebates are very significant in terms of the fiscal impact on states. And as long as federal law prohibited states from getting the rebates for prescription drugs dispensed through a managed care plan that was a powerful incentive for states to carve it out.

That has now been changed. And it is possible for states to get that rebate for drugs that are dispensed through managed care organizations. And as a result, half a dozen states have moved to reintegrate it. Some of the states are not yet there. I mean it took a lot of effort to carve it out and their resources are so stretched they're not in a position to kind of reverse that at this point in time. But for the reasons that Mary articulated from a clinical perspective, it does seem to make sense to have that benefit integrated.

On the issue of the dispensing fees, when you look at Medicaid dispensing fees compared to those that are maybe a health plan gets or a PBM, Medicaid dispensing fees do tend to be a little bit higher. Medicaid payment for the product tends to be lower. And what states have done and state legislatures in setting in that [inaudible] those two rates is to balance it between the two. So you can't just look at one.

DEANNA OKRENT: Thank you. And if I can take this opportunity to put in yet another plug for an upcoming briefing, on November 7th we'll be discussing some international policy and pricing issues with regard to pharmaceuticals. It should be a very interesting program. There'll be three international guests; one from the UK, one from France, one from Germany and an analyst from the U.S. as well to respond. So if you – if that is your interest, pharmaceutical pricing and policy, you – we might see you on November 7th.

Okay. We have another question on the floor.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. Most of this panel seems to be advertising privatized Medicaid. And saying the states really don't have the capacity to manage the higher cost, more complicated Medicaid patients anyway so let the private sector do it with these new tools of accountability that we have.

And I think Judy raised some interesting questions about whether we really have the data to examine the quality of care and the leverage to ensure that people with more complex health problems and particularly long-term care problems are going to get adequate care in this system. But we haven't really paid attention to all the levers of accountability that states have.

And when Mary shows the advantages of evidence based medicine guidelines and how effective they can be for certain populations that she highlighted, one wonders why states aren't enforcing those kinds of regulatory guidelines on the total population with those conditions. And what possible benefits there might be to the state treasury for reducing these unnecessary health care costs.

I also didn't hear any real attention to the ACO model except that that's another lever that states are using. And in fact, in Camden, New Jersey, they're getting a lot of attention for a hot spot or approach to ACO at a community level. I think that rather than back in to some precedence for privatizing Medicaid, we need to look at a range of policy options that ensure quality and efficient care for the total population. And I'm not sure that this Medicaid approach that's been described is really the best way to go.

And I wish that the panel – I wish that the panel was more balanced in terms of different models of public accountability in healthcare instead of really stacking it with one model and expecting us to see the value of that model. I appreciated Judy's cautionary tale but I didn't hear really an alternative to a more comprehensive community based approach to healthcare reform which is the state's responsibility and the federal government's responsibility.

And I'm afraid we backed into bad models for expediency purposes because we don't have enough state employees. We've already gutted the budget in different places. And so we back into things that we then ultimately regret having created these precedences for.

MATT SALO: Well on some level, welcome to the real world. [Laughter] Send me postcards from the Ivory Tower. I think if you want alternatives to and I think we're all trying to talk about alternatives to the status quo. And, there are a lot of different approaches here. I mean I think Judy is right. I mean you do have to be cautious as you move forward. You have to be as thoughtful as you can as you move forward. But moving forward is moving forward from the status quo into a system of managed and coordinated care.

And I think Dr. McCaslin talked about that's exactly what they're doing in a lot of levels in Missouri. I mentioned that certainly some of the options that a number of states are taking. It doesn't have to be a managed care entity. But, if again you can't pretend that budget exigencies don't exist. And I think that we are all trying to move forward to provide a better healthcare future for the people who desire it best.

So, I do take you're – if your one point is, as I heard, why can't the state just do a better job of driving more evidence based medicine, there are a lot of states who are

trying to do that. I would not, if I were you, down play how politically challenging that can be. I mean let's not forget that healthcare is 17-percent of this nation's GDP.

And that means that you've got 17-percent of the nation's GDP of people who are very powerful who have a lot invested in the status quo. And changing from the status quo which is not generally evidence based medicine to evidence based medicine means a lot of people are having their livelihoods threatened. And that is difficult to do. And it's a state does not necessarily have all of the levers to do that and to do that quickly. So.

JUDY FEDER: Just one additional thought. I think Bob what you are in part raising is that trying to change the whole healthcare system by looking at subpopulations is a challenge. And certainly in the Affordable Care Act, the bulk of the new tools are for the Medicare program although there is some authorities for looking at private sector experience. And we are very – because there's such a budget focus; we're focused on public programs.

But I think you are quite right to emphasize that healthcare is expensive for public programs because healthcare is expensive in general. And healthcare is – and sometimes lousy because it's lousy in general. And so the – to have a broader movement which some states are attempting to pursue and

there are all payer – some all payer innovations being pursued with the – in the innovation center.

So, but it's challenging. You know what Matt's saying. I don't think it's Ivory Tower. I think he just wants it – that voice to be on the table. And it's a budget problem; it's a healthcare cost problem.

DEANNA OKRENT: Well we're quickly running out of time. We've got one more questioner on the floor. He's been very patient so I'm going to give him the floor. But then we'll be closing shortly after that.

PETER MCMENAMIN: Okay. I'm Dr. Peter McMenamin, a health economist and senior policy fellow with the American Nurses Association. And hopefully I can get some comments on what I hope is not a series of innovations of Medicaid but seems to be occurring. And we hear reports of it.

When it comes to babies, Medicaid is responsible, I believe, for half of the children born in the United States. And we know that certified nurse midwives have a much lower rate of C-sections, much lower rate of NICU experiences. And yet it seems that there are some Medicaid managed care directors, maybe managed Medicaid directors, who are using the budget crises to save money by not spending money on providers who don't happen to be physicians.

In the State of Colorado in urban areas, they do not contract with any advanced practice registered nurses which as a former HIPPA person seems to be an obvious per say violation of statewidedness not to mention carving out the benefit package that's in Title 19. But that appears to be what they're doing. And unless CMS decides to eliminate the Colorado Medicaid program, that's going to be what happens.

I had a call earlier in the week from Arizona – no, excuse me, from Arkansas where they seem to be developing a list of CPC codes that they will carve out of the services that can be provided by nurse practitioners. Which may save a little money but you know restricts beneficiary access.

We've heard reports in Nebraska about restricting psych nurses' participation in psychiatric residential treatment facilities. I hope I got that right. And other places where they're just backing off. And although I was an AMA person for five years quite a while ago, one might, if cynical, infer that the doctors and other people in Medicaid offices are acceding to physician demands by – as I say, I'm hoping this is not an innovation. But we're seeing things like this occur and I'd just appreciate some responses.

MARY MASON: While one thing I will say is that in all this debate, healthcare is local. And that has always been a very important principle in our company because what happens in

one of our states can be very different in another. And I think the other thing that Ian said that was very interesting is access as, of course, is very different from his rural areas to his urban areas.

So I think that all has to be taken into account when you're building a network is to look at the local market, to look at the access issues. We want our Medicaid patients to have access to providers. But that may look different state to state. And so that's where I think it's just very import – it's not a cookie cutter solution across – you have to really look at the local aspect of healthcare.

IAN MCCASLIN: And we have no such plans in Missouri. In fact, we –

PETER MCMENAMIN: Good for you.

IAN MCCASLIN: – are very appreciative of the work that our advanced nurses provide in a variety of setting where we couldn't pay a physician enough to go practice at 85 miles east of Kirksville in the frozen tundra of the northeast. But there are many nurse practitioner led clinics and advanced psychiatric nurse supports and nursing facilities there. So, we're very appreciative. We do a lot of stupid things, make a lot of dumb decisions but that's not one of them. [Laughter].

MATT SALO: And I guess I would just sort of say that I – the clear trend that I see is actually in sort of the de-

specialization of healthcare. You know of looking to the physician extenders wherever possible. You know because access can be a problem now in Medicaid, sometimes not in Medicaid. And come 2014 when you've got 30 million people who are going from uninsured to insured, it sure as heck is going to be a much bigger problem. And I can guarantee you we're not going to grow enough physicians to see those 30 million people in the next two years. So we're going to have to start looking at those extenders.

One of the places where states do tend to shoot themselves in the foot though is a lot of state legislators have decided that because of local political reasons that it has to be a dentist not a dental hygienist. It has to be an anesthesiologist not a nurse [interposing] etc. etc. etc. And we know why they do that, it's a consolidation of power. You can get away with that when times are good. We can't get away with that anymore. And so that is changing.

PETER MCMENAMIN: Good.

MATT SALO: So hoping for the future, end on a positive note.

DEANNA OKRENT: Yes. Thank you.

MATT SALO: Try.

DEANNA OKRENT: Do you want to offer any last –?

VERNON SMITH: No.

DEANNA OKRENT: — comments?

VERNON SMITH: That's good.

DEANNA OKRENT: Okay. Well we've been grappling with a far reaching subject this afternoon, one that's on many people's minds and including the *Washington Post* this morning on Page 5. I don't know if you noticed an article entitled *Without Federal Stimulus Health States Find Medicaid Straining Their Budgets*. So [interposing] and it actually references [interposing] Yes, it references a new report. Vern is the author. Unfortunately it wasn't published in time for us to put it in the packets but we will put a link to it on our Web site along with the other materials for this briefing.

I want to thank you for your time and attention. I also want to thank our friends from Centene for supporting and participating in this program. Thank you for filling out the blue evaluation forms. And please join me in thanking our panel for answering [inaudible]. [Applause].

[END RECORDING]

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