Stakeholder’s Meeting

March 10, 2011
1:00 P.M.

I am John Selig, Director of the Department of Human Service, and I would like to welcome everyone here to our ongoing discussion about how to bend the cost curve for Medicaid. We always tend to get a big crowd when we start talking about billions of dollars and hundreds of thousands of people. But it is good to see people here and we are glad that people are engaged and interested in where we go from here on bending the cost curve. What we want to do today is update you on where we have come up to this point and talk about the concept that is on the table for basically changing the healthcare system in Arkansas and then talk about where we go from here because it will take a whole lot more work and development from a lot of people.

I am going to do a brief overview using the PowerPoint which is accessible on the internet. Then Gene Gessow, director of Medical Services, will put some meat on the bones. We will then open it up for discussions, comments, suggestions, questions, and complaints. And then Janie Huddleston, Deputy Director of Human Services, will talk a little bit about processing here, and how we might think about meeting with each other and developing the plan from here that works for folks.

As you know we met about a year ago and talked about transforming the Medicaid system because we could see that we have a significant shortfall coming in Medicaid. Most states, as you know, are already there. There are 45 states with significant budget deficits and what most of them are doing as I am sure you have read in the paper, they are making across the board price cuts to provider rates, trying to cut eligibles if they can get CMS to allow them to do it, slashing benefits, restricting enrollment, and moving toward more managed care. In fact they are handing the risk off to someone else and saying you do it for us.

We are trying not to do those things. Our situation in Arkansas is that we are OK next fiscal year because we built up money in the trust fund through the stimulus money coming in. We are one of the few states that are OK, not only this year, but next fiscal year. But in fiscal year 2012, we estimate we are going to have a shortfall in general revenue of $60 to $80 million dollars given the current budget projection. Of course that could go up or down and if we spend 1% more or less this year it will have an effect on next year’s assessments. When we get to 2014, another year out, we will rise to be about $250,000 million dollars short in general revenue and that is largely because, as many of us have talked about before, our health care costs in Medicaid have been going up just like every other health care system in the country. We have not put new general revenue into Medicaid in the last 3 or 4 years because we had stimulus money. Now we have that gap between our general revenue and the general revenue we actually need, and frankly, in 2014 when I talk about $250 million that is basically going to burn through our trust fund, we have to catch up. So we are facing a significant shortfall in the Medicaid program 2 or 3 years from now and we’ve got to get that gap closed.

There are 2 documents provided. One is a high level overview of our concept and one is more detailed from the policy standpoint. Our idea is that rather than making deep cuts in Arkansas, we would like to take what we are currently doing in Arkansas and get more efficient with what we are doing and spend
our healthcare dollars more wisely. You will hear a lot of people talk about where there is anywhere up
to 30% of our healthcare dollars, not in Medicaid but in total healthcare, is money we didn’t have to
spend because we are not particularly efficient. We have duplicate procedures, poor coordination,
people who get prescriptions and then don’t take them and end up in the hospital. We have health care
dollars that probably don’t need to be spent in the way they are. We would like to make this system
much more efficient.

We have a fee for services program that leads to fragmented care and volume based treatment.
Providers get paid for how many procedures they do. Both our Medicaid team and many of you have
submitted ideas for how we can change our current system. We could go to DRGs for hospital, do much
better coordination on people with chronic conditions and lots of specific ideas of what we can do. We
came to the conclusion that by looking around the country, taking our current fee for services and trying
to change it with a cafeteria plan of changes would not substantially bend the cost curve or give us a
more sustainable program. You remember we used the term bending the cost curve because we’re not
saying let’s cut what we spend now. Instead of going at the rate we are growing, let’s try to grow it at a
more reasonable rate. We know healthcare costs are going to continue to go up but they need to be at
a rate that is closer to what the state’s budget growth rate is because the state provides the money that
we put up with the federal money for the Medicaid program. We felt like these marginal changes would
work and we moved away from the idea of trying to implement 10 or 15 different things. That led us to
talking about what we can do that would literally change the way that Medicaid works and started
thinking about the entire health system in Arkansas. We came to the conclusion that it’s going to
require some payment reform for long term stability. The government has been talking for months
about moving away from fee for services. We need a new payment system that rewards high quality,
patient centered efficient care.

These are some of the things we are not proposing to do. At least we hope not. We are not going to
reduce the benefits for our clients, not going to do across the board provider rate cuts as so many states
are doing, we are not going to restrict eligibility, we are not going to just take our program and give it to
a managed care company who can then take a big fee off the top and say they will handle it for us and
you don’t know what’s happening from there. We’re not trying to do major budget cuts, we’re trying to
bend that cost curve. We’re not trying to say let’s cut 30% from the Medicaid Program, we’re saying
let’s not spend too much more than we are spending now in any given year that we can’t afford. We’re
not expecting all our providers to join an accountable care organization. That’s kind of a buzz word
these days at the federal level. It’s not clear what they are but for many providers and consumers there
is some sense that there is one big dog and some area of the state will control everything. We are
hoping that will not be set up. We don’t was a full risk capitated payments where providers are paid for
the number of patients they have and therefore shift the risk to the providers. These are all the things
we are trying to avoid doing.

Here is what we are proposing. If you all have read either of these 2 documents and particularly the
letter to the secretary, I understand it is mind boggling to get your head around what we are trying to
do. As it is while it is going under the current Arkansas system, it is a significant change and it took many
of us quite a while to hammer out some of this work just trying to bestow it to its simplest level. We are
trying to do 2 things. We are trying to create better health homes for consumers so they know where
they go for their healthcare and particularly those with more complicated needs that the care is more
coordinated for them. And the idea is that we would pay partnerships with providers. Rather than a
fee for service for individual services we would pay them for episodes of care for example, someone
who needs hip replacement. Rather than paying the hospital a fee, a surgeon a fee, the primary care
physician a fee, and whoever is doing the rehab a fee, hoping they talk to each other, the idea would be to pay a group of providers a fee. They should coordinate the care to make sure someone doesn’t slip through the cracks and 2 weeks into rehab have to go back to the hospital because somebody wasn’t checking what they needed to at home. We are trying to get providers to work together to coordinate the care for the consumer.

Here are some of the things we have been thinking about. We are emphasizing wellness and prevention. We want the people to live as independently as possible. As you know we have in this state, particularly those of you in long term care fields, we work very hard to help people to stay home in the community and live as independently as possible and we want to keep promoting that. We want to pay for effective, coordinated episodes of care rather than for individual services. Importantly we want to build off of the existing Arkansas system of doctors which may be different in rural areas than in an urban area, build off existing practices, referral networks, and partnerships. And we want to align the financial incentives to achieve an advanced system of care. We want to pay people in a way to cause people to provide good care and to do the things they need to be doing and not be doing the things that aren’t necessary for the consumers.

I want to focus on wellness and prevention. When we think about episodes of care we realize there are different types of care that happen. A lot of people think in the terms, you get sick and you need care. Diagnosis and treatment of disease—a medical model of care for episodes of physical and behavioral care (acute, sub-acute, and chronic). But we need to think differently about the wellness services. When you are pregnant you are not sick, which is a good thing. We just try to make sure there is a good outcome there. Contraceptive services, different types of preventive services, immunizations etc., those are not necessarily because you are sick, but because we are trying to help you stay well and stay healthy. Then there are long term care services for people whom we are not trying to cure necessarily but we are trying to provide health care to help them maintain where they are, to stay functional, help with their disabilities. We are just trying to support them. We spend a lot of money doing that and that is an important part and we don’t need to think of those consumers the same as someone who has appendicitis. As we work through this to develop these concepts we need to think of these 3 types of care giving.

Some of what we have been discovering is very important in this is 1, we think, on each of these, you could begin each of these to the degree possible. We know in some cases you can’t do any of these perfectly. To the degree that we have patient histories available, that we have electronic medical records available, we will expect the following. Providers will be responsible and familiar with each patient’s history and have information available through the information exchange to optimize treatment efficiency and outcome. We want the patients to be informed and engaged in all decisions related to their care. Medical-service partnerships will be expected to use the most efficient and effective delivery systems, methods, and evidence-based protocols. We want to work with the providers and ask, “For a particular diagnoses, what is the best practice these days?” and that is how we want to design the payment system, to pay for the best practices. We don’t want to pay for just anything out there, but we want to pay for the most effective care. And we want the providers to use good clinical judgment and that would be an expectation in this system. I think people would agree that this is what we should be paying for.

The steps we would take, and there are a lot of steps, but the first is to look at the current Arkansas system and identify how the best system works and what best practices are in Arkansas and elsewhere. Then based on that we can say “Ok, that’s how healthcare works and that’s what best practices are and
that is what an episode should look like for this particular diagnosis”. For a pregnancy an episode probably beginning at pregnancy and maybe go through the first month of life of the child whereas an episode for a long term care client might be a year of appropriate care. An episode for any kind of a medical model might be just for that particular illness and may last just a week. It’s important not to think that ok, an episode is just going to be a week or an episode is just going to be while they are sick. I think it is also important in thinking of episodes, we have not talked about us thinking of health care in 3 different ways. We are not saying that each of our clients will be put in 1 of the buckets that you are either a long term client, or a medical model client, or you’re a wellness client. You could easily be all three depending on your situation. We may be paying for multiple episodes for a particular client at a particular time. We would say this is what an episode looks like then in terms of figuring out once we pay for that episode we look at actual claims data working with Medicare, Blue cross and Blue shield and other kinds of insurance to see what are we currently paying for these services and therefore what does an episode look like. Then we also need to figure out what does health care and the partnerships look like and they might look very different from one community to another. In a lot of ways you providers currently have partnerships. Some are probably very formal. As a local physician you may have a formal relationship with a hospital. You may simply have relationships where you refer clients back and forth. You may be a community mental health center and part of your partnership is on your own staff. You may have a social worker, a psychiatrist, a psychologist and other medical professionals on staff and they are all part of the partnership. The idea is to try to figure out what these partnerships are and how we should reimburse them. The ideal would be that we would make one payment to the partnership and the partners would agree on the appropriate way to divide it between the providers for the services rendered. Once we get that work done we could start the transition through this new system.

Referring to Governor Beebe’s letter to Secretary of the U. S. Department of Health and Human Services, Kathleen Sebelius, I overheard some people yesterday in the public health community stating that letter was about health care reform. It is not about health care reform. It is about fixing our current healthcare system. The numbers I gave you from Medicaid are before healthcare reform hits. Obviously if we can fix our Medicaid system and the health care system in Arkansas we’ll be in a better position if and when health care reform hits. The meeting with Secretary Sebelius, the governor’s discussion with us was, when we have a concept we think might work, and because of the required approval of CMS to do this, we need to make sure that Secretary Sebelius and CMS thinks it is worth pursuing with us. If they said no, there would be no reason to bring out a plan like this because it would be dead on arrival. He met with Secretary along with Gene Gessow and Surgeon General Joe Thompson a week and a half ago and got enough positive feedback, yes we are going to look at this. Of course she was caught up with 45 states saying can we cut this and cut this, and then Beebe came in and said we have a new idea. Kind of hard for a Republican to absorb this but she was interested enough and said yes my staff will look at this and see if we can make this work. I think that then Governor Beebe felt this is something we want to start pursuing.

Here is what the specific request was for Secretary Sebelius. That she really support us. Our argument is that a lot of points in this plan have been tried in different ways in different places but nobody has moved together on a statewide level. People have tried different types of payment formulas trying to pay for representative care. On a statewide level it would take political support for the required Medicaid waiver for development of a new payment strategy. We asked her to include all Medicare recipients. It was pretty clear to us early on that if you just did this with Medicaid, one, there is probably not enough market leverage to make it happen but also, it wouldn’t be good for providers and clients, particularly the providers who are saying Medicaid is not going down this road, then the private sector is going down this road and who knows where Medicare is going to go and how many different
systems of care we are going to have to have for our practice. We need in the private sector and Medicare need to be headed down the same road toward the same goal. Before meeting Secretary Sebelius, Governor Beebe met with Blue Cross and Blue Shield as the biggest private provider but by no means the only one we want to work with. Interesting enough they said “we’re actually headed this direction also” and immediately said they wanted to work with us in developing this plan so Blue Cross is already onboard and we believe other private payers are interested in working with us. That doesn’t mean we’ll all end up with exactly the same systems but ideally we’d like to give providers the same signals, the same incentives so you don’t feel like you are getting pushed in lots of different ways.

Governor Beebe is asking for a contribution of fiscal and intellectual support for development and implementation. He didn’t go up there and ask for a lot of money but did say we are really going to need your help to make this work. And this is what the timeline is. We told CMS that we would really like to know by May whether they believe this is something that they could eventually give us a waiver to do. We don’t know if we can get all the details worked out by then but we saying we are on a tight timeline and that we need to know in a couple of months whether this is something we really can go forward with. In the meantime obviously we will keep trying to thrash it out with you all. We would be working on these partnerships and pricing episodes to work out what we will pay for. We will work on that between now and May 2012 over the next year or so and start to put some of that out in May of 2012. Over the course of the next year we roll out different pieces of this and implementation in July of 2012 and will probably take about a year and a half with the idea that we would have it fully implemented by January 2014 if all works well. So generally that is the timeline for this. And we do feel some real sense of urgency to make something work here as we get closer to fiscal year 2013 and 2014. We don’t see a lot of options outside of the significant reform like this for avoiding the things other states are doing. We’ve looked hard, and we have the same things at stake, coming up with other ideas for making significant changes in their healthcare systems. So we think this is a concept that will work. Obviously there are many pieces as we get into it. We may decide what we felt would work this way, but, you’re right, we should do it this way for this group of providers, but it would work better this way for this other group. We think there will be a lot of work to do to get a general sense of what will work.

At this time we’d like to turn the meeting over to Gene Gessow, our Director of Medical Services to put a little meat on the bone.

Thanks John. He has actually put a lot of meat on the bones with the overall concept. I think there are a couple of points. We have asked for a waiver, as part of our asking of CMS and we have said that by May we would like them to agree that this is something worth pursuing. I will explain a little in detail what actually we are envisioning. We are envisioning that by May 1st CMS will have an idea of what we are trying to do. And we envision that between now and May of 2012 we will have put the meat on the bones and to really setting a pretty high standard for ourselves by saying to Secretary Sebelius, “you know that waiver you said you’d think about with us? Well, essentially, we want you on or about May 1, 2012, to take a look at where we have come over the last year and a half—what we have accomplished”. Can we insure her that we have enough providers who are willing to engage in this system to provide access to care for all people on Medicare? That is the standard. If we don’t have the providers we won’t get the waiver. That is the standard we have set up for ourselves. We have also said that we believe, in order for this kind of new system to work, Arkansas Medicaid as well as perhaps other private payers have to be more than simply be payers. They have to pay a more active role in the system. Now in the past, an active role in the system has generally meant more utilization, more review, and more rules about what you do and don’t do. We actually contemplate a different kind of action in this particular case. We know, for example, or believe, that the medical home concept which is discussed
widely is an excellent idea. The ability of providers in different parts of Arkansas to become medical homes that meet the national oracle and the state standard will vary. A one person practice or a two person practice may not have the opportunity to hire a care coordinator to follow up with every patient and so forth. And we believe that one of the roles that Medicaid needs to play is as a utility service available to such providers to help them meet the standard that we expect for a medical home, to enable them, to empower them to get to the right result. It was not simply us standing there saying you should do that and give me a call when you’ve got it done. We actually want to be partners in helping you get that done. And similarly we have said in our letter to Secretary Sebelius, we don’t think it will unless we are willing to do that, unless we have laid the ground work to do that, unless we have helped people get the electronic medical systems that they want and will be able to use, unless we help them help their clients get engaged in the healthcare system. So you have to judge what we are doing, not just the planning and the regulations and we need to establish that as one of the conditions. We are setting ourselves up in a sense. We are setting ourselves very high standards before we pull the plug or before flip the switch on this idea. To get to where we want to be in May 2012 so that we can begin the phase-in of this process we have an enormous amount to do. By the “we” I mean everybody here and there is no question that Arkansas Medicaid can’t do it alone, Arkansas Medicare can’t do it alone, Arkansas Blue Cross and Blue Shield can’t do it alone, the providers can’t do it alone. The only way we can make this work is if we work and do it together. To me, that is the most important point just as an example. Sometimes it’s only the end result that you look at; I don’t care how we get there-just get me to the church on time. I don’t care how you do it, just get it done. That actually is not an approach that will work in the particular case. Essentially there is nothing inevitable about where we get, how far we get, and how we get there. How we work together to get there is going to define the property of the likelihood of the result. Given the timeframe we can’t take forever and have conversation after conversation. That doesn’t mean we can’t have and don’t need to have lots conversations but we have to make sure that each one of them are as meaningful as possible. One of the ways that you have a meaningful conversation is to have a very specific agenda of things around which to build a conversation. Something to talk about, ideas to play off of, that is what we believe we have put on the table. We have a starting agenda for a conversation; we have suggested where we want to go and where we don’t want to go. That was a big if, but that is only the first step of a thousand steps that we need to take.

Thank you.

We will take questions now.

Question:
Gene, the question I’ve got is dealing with the criteria that the state would consider using if the state goes to that direction for medical home certification. We have NCQA with their standards to meet for medical home. But if we also accept one of the premises in the letter that there might be a state medical home criteria, will you have a committee that designs that criterion for us to use?
Answer: (Gene Gessow)
Yes, we will work together on how to implement that medical home concept in Arkansas. We will not pick something and say that’s the one we are going to do.

Question:
Will there be tiers or levels of medical homes or not such as NCQA have looked at?
Answer: (Gene Gessow)
I don’t know.
Question:
I want to ask a 2 part question. Regarding the partnerships, is Medicaid going to provide funds for these groups of providers to create these partnerships and to administer these partnerships? On the episode of care payment, if the amount of care needed to take care of that patient exceeds that amount, is Medicaid going to provide that to the provider or is the provider going to have to eat it?
Answer: (Gene Gessow)
Let me answer the first question. One of the things we have specifically contemplated and discussed is that we would provide or be able to offer as a utility service the administrative support the partnerships would need to operate. With our new MMIS system we will be able basically to take your partnership agreements and help you, if not entirely administer those agreements per your instructions. The answer to the question is we will offer that as an available utility and support service which you will not have to pay for.

Question:
What about the legal cost involved in setting these partnerships up?
Answer: (Gene Gessow)
I once got a legal degree but I am not practicing law now. A partnership is the simplest and most flexible form of business organization. If there is an even simpler one by which we denote we are ready to commit to that as well.
The second question that you asked is about whether or not our goal is to say gotcha to the provider. “You got the wrong patient and you are out of luck”. Here again, you will see in the letter, and that it says in a few words what is a big part of our message. We do not intend to do a capitated risk shifting program here. That is not our goal at all. Why, for example, we picked episodes of care rather than capitated managed care, that was one of the main reasons. We wanted the payment system to be sensitive to the individual criteria and situation of individual clients. We didn’t want to say “take these ten people and best of luck” kind of thing. That is specifically why we chose payment on an episode basis rather than payment on a monthly capitated basis to avoid that kind of risk giving.
Answer: (John Selig)
I’ll just add on to Gene’s point, if there was an unforeseen complication, we could adjust. If the provider partnership did some things they didn’t need to do, such as run a test twice, we probably wouldn’t pay for the extra test. But we are not out to put you at risk for medical situations you couldn’t anticipate.
Answer: (Gene Gessow)
Clearly the issue of cost cutting conditions has been part of the conversation now for a long time. That’s not the foundation on which we built this. Nor is the foundation on which we built this about risk shifting. It is about recognizing that healthcare providers are well equipped to manage the system of care which they deliver and that it is a reasonable expectation to assume that they do so efficiently and effectively. In an uncertain world in which there are lots of things that can go wrong, still there is some control that you can have.

Question:
John, who decides what treatment is necessary for a patient and the payment on that? Who decides that they went above and beyond?
Answer: (John Selig)
Part of that is where we work together with groups of providers. You might get doctors together to look at episodes of care for what they did and figure out what is an appropriate episode of care for different types of diagnosis. Part of what we need to think is if there is some kind of complication, how you make that decision. I don’t think we have figured that out yet. I think our commitment is to not leave
someone hanging like that and that we want to come up with a reasonable package that we pay for knowing that there will be a lot variation.

Comment:
It is not necessarily a complication; it’s just that patients are different.
Answer: (Gene Gessow)
And that’s nothing new. You can say the current healthcare system has the same weaknesses.
Answer: (John Selig)
And that’s even true with office visits, some may take 3 minutes and some may take 25 minutes but you don’t necessarily get paid differently for this. It’s a good question, at a certain point you do. I assume you don’t get paid by the minute.
Answer: (Gene Gessow)
One of the things we don’t have any expectation of doing is to build a perfect system. We are trying to build off the existing system, look at some of the trends that exist in the current system and work with them to re-balance the system so we have a little less weakness and a little more strength. And that is a good and reasonable and practical goal.

Comment:
When you spoke of the episode of care I had this vision of this episodic care payment being thrown up in the air and the hospital and the surgeon and the primary care physician and the anesthesiologist and the pathologist and the radiologist all fighting over who gets what.
Answer: (Gene Gessow)
And that is a vivid picture. I also have a picture in my mind of someone leaving the hospital after two weeks stay and extensive surgery, hearing the door slam shut and wondering what the hell happens next. Do you know what happened behind the door? What’s the hand off, the trade off, the transition? You need a team to take care of you. The anesthesiologist has to talk to the surgeon, the surgeon has to talk to the hospital, the hospital has to talk to the primary care physician, and everyone had better consult the pharmacist. There’s going to be a rehab person involved in most cases. We don’t necessarily have a system today that says you are all part of the team and you need to act like a team for the benefit of the patient. We are trying to find a common sense way of getting all these people to work together on behalf of the patient. Put the money in the middle of the table, and tell them you all know what the payment is; you all worked together before so let’s get together and figure out how to divide this out. It’s our job to take care of the patient not just his job or her job or his job. There are many examples on both sides.

Question:
This is not a provider question but what kind of choice, if any, does the Medicaid recipient have in his or her medical home?
Answer: (Gene Gessow)
Hopefully they will have more choice than they do now. Let me give you a couple of examples. Right now we have a PCCM program and we have had one for the last 25 or 30 years. Individuals get a chance to pick their PCCM now and we are using that PCCM as the seedling of something else we are trying to grow so we are not going to cut back on patient choice there. In addition to that in order for a patient to exercise real freedom of choice it’s not only a question of evaluating a doctor they see, but its making sure the doctor has time to tell them exactly what they are getting themselves into when they have a test or a new medication or they go in for surgery; to engage the patient in helping to make decisions about their care to empower the patient. And a number of things, at least 2 things off the top of my head that I can think of regarding the power of the patient. 1. When we price the services of the
doctor, we should assume or take into account that he or she spends time with the patient telling them what their options are instead of tempting that doctor to run as many people as possible through the system so he or she can keep up the patient volume on which his earnings are based. And the second thing is: We want to make available to patients the kind of direct assistance in getting care and receiving care. For example we want them to be able to have access to their personal health record. We want them to have access to somebody if they need it or ask for it that can help them manage how to get to their appointments, who can help them to understand what medication requires them to do, who can answer that question at midnight if it keeps them awake. That’s the kind of thing I think will provide more choice for patients, more control over their life and the health of the patient.

Question:
Going to your episode of care, how does one determine when your episode of care ends and another begins if you have complications?
Answer: (Gene Gessow)
I am not a doctor and I need to be real careful here. When you talk to people, you might ask did you have a cold last week. Yes I had a cold last week. Is it over? Yeah I guess it is pretty much over. Did you break your leg? Yes I broke my leg. Did you also have the flu when you broke your leg? In a very practical sense, while you might not know to the minute when things like that begin and end, I think it is a practical matter. Let’s say in 75% or 85% of the cases it is pretty clear when an episode of disease for which you receive care begins and ends. We’re not going to be able to develop a rule that will provide an absolute clear blue line in every case if we can get within 90% of the cases, and if we can have a reasonable way to consider the exceptions in the other 10% of the cases we’ll be doing well.

Question:
And with that being said, because I assume you are considering a global reform, is what we are hearing, you’d deal from here to here, would it be a private factor?
Answer: (Gene Gessow)
No not necessarily like that. Part of the things we intend to use is the existing language of healthcare so if you look at the ICD9 classifications it will begin and end with the treatment of a disease so classified in the ICD9. In some cases an episode may last an hour and in other cases it may last 3 months and it depends.

Question:
Gene you may or may not have meant it when you said providers are only providing care based on incentives on which they get paid and some of us have taken offense to that. You also didn’t answer the gentleman’s question about how the individuals within the partnership get paid out of the episodes of care money. Or legal fees or charges. Is there a place we can go to look at certain current models for partnerships? When people join a partnership, there are legal fees, then the division of malpractice insurance. If they say we’ll give you $5000, you guys split it up the way you want to. That is going to be a very cannibalistic type of thing for doctor’s fees. There needs to be some model, not just give it to the partnership and you figure it out.
Answer: (Gene Gessow)
I have said that I do not have all the answers to those questions. I would suggest you look at the evolution of health care market and how health care providers come together, split apart, integrate, and build their own and other networks. These partnerships do exist. One of the things we didn’t want to force physicians to join hospitals in order to be a part of an accountable care organization. We didn’t want to force people into a particular model and we want to give them maximum flexibility. The most flexible business model is a partnership. You can make it be whatever works best in your area. It is true
that different providers might want a different share of the pie. That is absolutely true. That happens now. I sit on the 4th floor or anyone else in other places and somebody comes and says pay the hospital more, or pay the doctor more, pay more for this, pay more for that. Medicaid is the “you” company. You decide who gets the most. You decide who is most deserving. We don’t want to decide. So besides the decision is not made, the question is whether or not we can, at the insurer level, have the Wisdom of Solomon that tells us how the system should be designed in each part of Arkansas to work fairly and then how the reimbursement should follow that. So the idea that the decision is not made is simply incorrect. That is what our whole system is about today. It’s about making those decisions and deciding who gets what.

Question:
With the theory right now that the decision is made fairly across the board within certain partnerships, won’t they have thousands of these real decisions to make each day against different partners?
Answer: (Gene Gessow)
It would be mournful for me to think that our current system doesn’t fairly and across the board invest in the best way that meets the best interest of the patient and the best interest of the taxpayer. If that was the case, if we had a very fair, very consumer centered system, and every provider agreed, we probably wouldn’t have to do this.

Question:
I have an understanding about what went through my head when we talked about already having integral partnerships. And thinking of the people I represent I thought absolutely. They work with various hospitals, they work with various physicians. At the same agency they work with 2 or 3 hospitals or 4 or 5 physicians. Some physicians may work with 4 or 5 agencies; let me put it that way. Now I thought I heard you say you establish a partnership on the front end. It doesn’t sound like the same informal partnership I had in mind. That his patient may be working with this physician and this hospital and this home health agency. Then this patient may work with the same physician but a different hospital or different home health agency. Is that not a possibility? Will they have to have formal partnerships for this to happen?
Answer: (Gene Gessow)
Yes. This is one of the things we are going to do. Right now we want to stop and think and we are asking providers to do the same. Stop and think exactly how you can stay in practice today. What partnerships would you use today? In some cases these 4 people are not, and in other cases these 4 people are not. And generally it’s either those 4 or those other 4 and what varies is the means of appropriation. Ok so you have 2 partnerships and you have 2 partnerships. Nothing stops you from having 2 partnerships. We want you to build on existing partnerships and to strengthen those partnerships. So we are not trying to reduce the number of options you have, we are trying to expand and incent you to work closely together.

Question:
So a physician may have a partnership with 4 different home health agencies?
Answer: (Gene Gessow)
Yes

Question:
John it is true that 10% of Medicaid recipients consume 70% of the dollars and that is just what we have heard. And the other 90% get 30% of the dollars which is a government math trick. For every dollar you are spending on the 90%, you are spending 20 or 21 on the 10%. Wouldn’t it be more practical to refine
all this using that population of 80,000 recipients versus 700,000 recipients? Wouldn’t that be a smaller bite of the apple?
Answer: (Gene Gessow)
Let’s just think this through for a minute. Let’s agree that we are talking about 90% of the cost and 10% of the people. What we are proposing is talking about allocating that 90% of the cost. It’s talking about payment for 90% of the cost. We aren’t saying that every patient has to be in a partnership or associated with a partnership. What we are saying, for whatever care we have, the 90%, let’s figure out how to pay for those dollars.

Question:
What I am getting at is your overall payment for recipient right now is around $5000. If you look at the 10% of the patients who consume the 70% they make up a group. For the lower group, the 90% of the patients that are getting the 30% of the dollars, that means your average payout for whatever purpose, is roughly $1500 or $1600. Whereas the other 10% average payout is roughly $33,000. To me it seems like you would look at that group and see if you could reduce that payment ratio from 20%-1 down to 17% -1 or something like that.
Answer: (John Selig)
Part of what we have to decide is where we focus our efforts and I think one of the places we want to look at is where is the money going. Where can we have the biggest impact? It may be that most of the effort goes toward those who are the 10% diagnosis that account for 70% of the cost. I think ultimately we want the whole system working in the same way. I think it does make sense. We don’t want to start with those diagnoses that happen once a year.

Comment:
I have determined that everything that has happened over last week is that we are talking in the universe of 770,000 recipients and all those recipients are going to be assigned to a partnership and want us to pay for their services.
Answer: (Gene Gessow)
Right not everybody in Medicaid is assigned a PCP. The partnership becomes after that when someone needs care. 700,000 people are under PCPs. That doesn’t mean 700,000 people get care. Only 10% of those do. So only 10% will be in a situation and you can figure maybe 50% of the 10% actually will need the kind of care that involves more than one provider. That is what we are focusing on. Partnership is a partnership of providers. It becomes active when it’s presented with a problem. It is not going to become active just because you have a list of patients. We have a PCP program and we want to keep that which means we do want to keep all 700,000 people connected in some way but in that initial connection we want to improve on. But that doesn’t mean that we are automatically assuming that all of those people are already cared for in a care partnership.

Comment:
But that any of them could at any time?
Answer: (Gene Gessow)
Yes of course. And when they do we need to be prepared to provide them with the care they need. Pay the payers what is appropriate; pay the providers what is appropriate. And that is what we are talking about doing.
Question:
John, I have just one more question. It deals with payment or reimbursement or whatever the phraseology is. Will there be variables for the rate dependent upon the social incumbent of help— isolation, disparities, and availabilities?
Answer: (Gene Gessow)
No, this is not an insurance type of payment. It is not a set of rate cells where the client is old, and in the eastern part of Arkansas, and they pay more for insurance. It is not a rate cell. We are not trying to make capitated payments to providers based on the profile of their population.
Answer: (John Selig)
If a patient’s developed situation caused their need for care to be different then payment will be different.
Answer: (Gene Gessow)
We will supplement that so that we will be able to help you fill in what is necessary to get the care delivered. Sometimes, for example, might be when a provider may say “I’m not in a position to provide that”, that might be a one of utilities we would provide through a contract with somebody.

Question:
And the other piece I wanted to address is the patient’s ownership responsibility for his or her episodic care. Where is their ownership and where does it fit into this concept?
Answer: (John Selig)
Do you mean by the patient’s ownership, for example, the patient’s responsibility to take the meds?
Comment:
Yes. Where does that fit into this concept?
Answer: (Gene Gessow)
It fits in this way. One of the things we assume that we need to do is to build a system that empowers the patient to do just that. We know we can’t force them to do it. But if, for example, you can give them a personal health record that they can read and give them some assistance in understanding how they might use that, then that empowers them. If you can take into account how you are paying your provider that the provider needs time to explain to the patient and to the patient’s families, what exactly is going on so that he or she can make the right decision that helps empower the patient. So you can’t force the patient to do something but you can give them an opportunity and give them tools and give them time and give them attention that they haven’t had before.

Question:
Do you envision payment for outpatient prescription drugs that you find in a certain care event?
Answer: (Gene Gessow)
We are starting out with the assumption that we look at everything that is used to diagnose and treat a patient. Clearly pharmacy is a very important part of treating a patient so you couldn’t take that off the table from the beginning and assume that it has nothing to do with the treatment of a patient in an episode of care.

Question:
As a provider of services for people with disabilities, I want to make it clear that I am not anti-bureaucrat. Some of you are best friends. When you say there is no intention for this to be a “gotcha” kind of thing, I hope there is some money available to retrain some of the bureaucratic personnel. Because, I know you don’t want it to be but that is a big part of the system today.
Can you please express a little better what you mean by that? I don’t mind being called a bureaucrat; I’m just not sure what you mean. Do you mean our staff in the field?

Comment:

I mean the people who have the negotiating power with those of us who provide services. Especially when budgets get tight, it becomes “you’re not going to get this, or not going to get that” and “you can apply for this, and we turn you down, and you can appeal”. Then it becomes different in what the families need and what we say you can have.

Answer: (John Selig)

Yes, I think it is reasonable to determine that it is always going to probably be those tensions no matter what kind of system we have. It is truly not our intent to make this system weak. We are not trying to pull a bunch of money out of the current system. We are just trying to use our money better and trying to figure how to do that.

Answer: (Gene Gessow)

I think it is fair to say that the reason we are trying to do this is to preserve money, is to preserve the integrity of the system so we don’t have to slash and burn which would result in a lot more of that. So this is an alternative to that.

Question:

From the Insurance Company point of view, can you help me with the question that if we have to interact with multiple partnerships, which we likely will since we are in that high end group of folk, is there an easy way to do that or is it going to be shoe leather proposition?

Answer: (Gene Gessow)

Well, my guess is that there is not an easy way to do that. But my guess is we all respond to Children’s Hospital. We can figure out how to do it. Sometimes you don’t want to work with the departments around the state. You want to have partnerships and you want those partnerships to be vigorous and real and ongoing. So this is your opportunity to empower you to get that done.

Question:

It hasn’t been that many months ago that we were talking about the MMIS process and alternative considerations. How do you see this particular transformation process fitting in with that process?

Answer: (Gene Gessow)

The new MMIS system will make it possible to provide the administrative support and the analytical support necessary to maintain this new kind of system.

Question:

From a single entity providing those services or are you still thinking along the lines of an alternative possibilities?

Answer: (John Selig)

Have you seen the latest description that is on the website? We were talking about a MMIS system and at one point had 25 different pieces in the RFP. A number of those have been collapsed. There are still a few pieces but not near as many as there were. I don’t want to go much deeper but they do support each other.

Question:

Something that you can’t have is successful payment reform unless you have tort reform. Will we consider the cost of litigation on the cost of care and be able to legislate tort reform as necessary?
I think for all of us, tort reform can be on the table, off the table. We don’t see this as dependant one way or the other on tort reform and others have dramatically different opinions on tort reform. So how about we stay neutral on that?

Question:
I think I have some questions as a DD provider. I think I understand the definition of episode of care when you use something like a broken leg or something that is curable within a short period of time. With developmental disabilities and the DDTCS or a CHMS clinic, it is not something you just cure overnight in your field and go on. How does that affect DDTCS and CHMS care?

Answer: (Gene Gessow)
The episode of care as a payment the care system will behave differently much more like we want today. Clearly a person within the DDTCS services might have the flu might also break their leg and might also have diabetes just to treat them they will need several different levels of care. It wouldn’t make it harder.

Comment:
Would the DDTCS CHMS provider have to be in partnership with the primary care physician?
Answer: (Gene Gessow)
You say would they want to be in a partnership? Clearly any provider who provides prime care services would want to have a relationship with the primary care doctor of the people that they serve. If that person had to go to the doctor and go to the hospital they would want to make sure that all that stuff came out and that they were in a loop and hopefully this will encourage that kind of looping tactic.

Question:
Tell me how, if we aren’t going to cut services and eligibility, we’re not going to cap rates or cut provider rates, how are you going to achieve savings for this huge thing.
Answer: (Gene Gessow)
The underlining assumption is that there are, not because of any fault of any particular party, inefficiencies in the existing system of care. So for example, it is possible for people to get more than 1 test of the same kind. It is possible for a person to stay in the hospital longer than they need to because the hospital on admission didn’t have access to all the patient records and were not aware of some issues they should have been aware of and it could have been that if they had the information it could have changed the things they would do. What we are focusing on is trying to find those kinds of things in the system. Again, as John pointed out, there are people who say it is up to 30%. I don’t particularly think it is around 30% of the system. But is there enough there to concentrate on doing the things we don’t need to do, or stop doing the things we don’t need to do, in order to provide care with good outcomes to people. If we can find within that group of activities enough money so that we can preserve the integrity of the system and continue to grow it and not keep people off or cut rates because we can’t figure out how to do it. It is a hope. The idea that we could believe and say that finally without cutting people off the program, without cutting benefits, without cutting rates, without buying into decapitated managed care. We can’t give a guarantee but it is worth the try because the other 4 alternatives are not themselves attractive so we’d like to try that first. And give it a good faith, hard charging first effort so we don’t have to do any of the other 4 things.

Answer: (John Selig)
I want to come back to the question on DD services. I don’t think the offset terminology is still working well. I don’t want to give the impression that nothing will change for DD services. I think we are still
going to want to look at, for instance, activities for individual services. It may not be something called episodes but we are going to look at that. We are going to want to look at paying for activities of daily living day to meet the needs as opposed to paying for specific service such as personal care or nursing home care. We are going to have to together figure out how to look at those to make sure we are creating the right system.

Question:
I don’t understand what you said about activities of daily living.
Answer: (John Selig)
For an elderly person, rather than saying let’s pay for personal care and home health and for nursing care or whatever it is, we would say based on their situation, their needs and activities for daily living, what is a reasonable payment package based on what someone in that situation should need that we would want to pay for. Then the partnership of providers, which in some cases the provider would be his own partnership because he does a lot of different things, would then decide what base of services to give them as opposed to going for a specific service.

Comment:
Is that like cash in account thing where you figure out what the package was worth?
Answer: (John Selig)
Almost like cash in account, exactly. We’d say his is what the package is worth. I think in some cases the waiver works like that-you say do what with the money available, what is the best set of services to provide for that client. We are thinking along these lines.

Answer: (Gene Gessow)
One of the characteristics of the system we are trying to shape in the long term care area is to continue work that has been done so far in filling in the continuum of care, the long term care, that ability to find the right place in the system at the right time of your life and be able to move to another place if you need it and not get stuck. And there are lots of things that have happened, 1959, independent choices and all those things. We want to continue to move in that direction.

Question:
I have a question as a member of children’s clinical hospital commission and as a local school board member, I am curious how school based care will fit into your model at this time.
Answer: (Gene Gessow)
One of the things we want to develop and to enhance is the efficient use of all our medical resources. And most efficient is the position of our forces. I think the governor has made it clear and the Department of Human Services has made it clear that we see school based health as one of those outposts or stations in which an efficient statewide system of care the school based health will play an important role.

Question:
I work with several different insurance carriers. Is part of your plan also from what is ty and administrative initiative? I have obtained from some of the carriers I work with, dealing with Medicaid and trying to be determined who is primary or who is secondary, they end up having Medicaid come back two or three years later and they are wanting to change some information that don’t get placed properly. There are claims that I have membership cards that things have gotten paid in duplicate, things are not getting caught and followed up on. Is that part of the program too?
Answer: (John Selig)
Part of the reason we feel like maintaining a sense of a quality healthcare system moving in the same direction is so we don’t make it worse. We also have worked out that we can’t use the same platform we use now. We want to be coordinated, so, yes. I certainly can’t give you a lot of details now. But one intention now is to streamline a bunch of that.

We don’t for a minute think this is going to be easy. And you can tell we don’t have it all figured out and it’s going to take a lot of work. As Gene has said and as I have said, we do believe that a fee for service system is not something that has a long term standing in our system. There is not a state in the country that we can see that has found a way, in a fee for service system, which can keep their costs at a reasonable level so they will have to make a significant change. This is the model that we are putting on the table but we are obviously going to need a lot of help from you to help us figure out how to make it work. And there may be pieces of it that we have brought up here that we ultimately say that is actually not the right way to go. We need to do that piece differently. We are not at all wed to this exact model and exact way we’ve got it up here. We thought we’d hang this up there so that we could all look at it and see what works here. What we do believe is that we have build on the system we have now and we do believe we have to build on some of the strengths of Arkansas. That is where we are trying to go now. More than anything, we’d sure like to not tell you what—for us right now seems to be the alternative that I have talked about and Gene has, that if we really in the next few months are not headed in the right direction we are going to be forced to look at those kind of things that none of us want to do. And as you all know, you start talking about even 60 million dollars, much less 250 million, 60 million dollars, those are really serious services. If rates were to some degree not on the table, the types of services you would have to eliminate to be able 2 years from now to be spending 60 million dollars less, 250 million dollars less are just terrible choices we’d have to make.

Question:
John, do you have an idea, when certain people come in with the exact same diagnoses but the treatment was radically different. We’ll say a clash, where one of your providers that promise you and they see you in 3 weeks, and the other one of the providers recommends group session. With the same diagnosis, it would probably go to treatment. It could be sleep apnea, help with loss of a hundred pounds, you have to have you tonsils out, that sort of thing.
Answer: (John Selig)
My assumption, and Gene may have a better idea, is when we sit down with a particular diagnosis can be treated in different ways. First of all, we’ll have to say is there more than one effective treatment? If so, if one costs 3 times as much as the other and seem equally effective, we probably like to pay for the one that is not as expensive. We would want to create those payments for episodes that allow for equally effective treatments at a reasonable cost, even if it is from a different perspective.
Answer: (Gene Gessow)
We want providers to be able to use their professional expertise.
Answer: (John Selig)
We don’t want to pay for something that wasn’t that wasn’t that effective. But we realize there is more than one approach to diagnosis.
Answer: (Gene Gessow)
One of the things we are trying to do is encourage a conversation among providers and medical professionals. The kind of conversation that probably takes place at a medical convention. People sit around and say how do you handle this case, or that case? Well I do this, well that may not be a bad idea, well I might be able to do that, it might work. They continue to learn and change. That is part of
the whole theory. The providers will take responsibility collectively for figuring out what the best way is of doing it.

Question:
Right now I’m not talking about best practices, what I am talking about is an individual diagnosis that has 2 totally different ways of treating it because of the severity of it, with exactly the same CPT Code. How do we tell you this is not a simple fracture, this is a fracture that requires an overnight stay?
Answer: (Gene Gessow)
Right now you can’t do that with a CPT code but you will be more likely to be able to discriminate based on the use of ICD pin codes and ICD on codes because they are more regulated in their ability to describe a condition than a CPT code is which describes a service. We are going to use the same language but we are going to pay more attention to the on our side to the ICD codes.

Question:
With this in mind, right now, you can have the same ICD 9’s and have totally different treatments.
Answer: (Gene Gessow)
Yes, and we are not going to reach a perfect system but one of the reasons we are going from ICD 9 from ICD 10 is to create a more granulated picture. And hopefully, with the use of those codes, with the addition availability of electronic clinical information, we will be able to get a much more norms picture as a third party payer of exactly what we are paying for than we have in the past.

Question:
I can hear you there; I think it will really help.
Answer: (Gene Gessow)
We are doing our best.

Question:
A part of what he is referring to on his point is the whole reason why the Medicaid Incentive Program, PMR System came out, initially why they sold it to us, was for that purpose. For all this new electronic data, already compiled, put it all together in fine print, to adjust and expenses along the way. That was the reason for the incentive program that’s already in place. It’s yet to be played out but it is in place. But what you guys are going is cost and consult management. And his point is very valid in that by trying to do episode based fee schedules, you are basically managing cost of consult. There are 2 different points here. He has hit all the good ones so far. You can get away from billing by the hour and flat fee billing because, basically, with a little massage will get your cost of consult on track. What he says is true. You can have two cases present the exact same thing but because of their home life or their social features or whatever, with this and that illness, although the ICD 10 and the CPT is exactly the same, the care necessary to treat client A will be substantially more expensive than to treat client B because they didn’t have smokers or whatever the case may be. So if you set a fee down to spread among 5 doctors or 5 different specialists to treat those same 2 sicknesses, your cost of consult is getting spread out, whether you want to admit it or not, that is a danger to life because they are going to end up fighting over whatever piece of pie they can get.
Answer: (John Selig)
Our attempt would be to be able to deal with those variations, for you to be able to say this patient has particular complications or something in the home like smoking that makes it more difficult plus be able to make adjustments. Not just to simply say it’s an appendectomy, $2000. We understand there are those differences and be able to adjust to them. I think, with ICD 10 and the new MMIS system, we
want to get these sheets as granular as we can in reason so we can pay you specifically for what your need is.
Answer: (Gene Gessow)
It’s the opposite of capitated care. We are trying to look more carefully to the specific patient and set prices accordingly.

Question:
Would it be fair to conclude from your remarks that the reason for the timeframe you mapped out both for the RFP, the MMIS System, and this letter from the governor, is the intent to make some progress and have some results in hand in time for 2013 and 2014 you mentioned earlier?
Answer: (John Selig)
In a unilateral system, we’re simply required to read in that we have run the length of the current so that is what primarily going to happen. The sense of urgency here is because we’ve got this billing budget situation and frankly good health care reform is that we get and 250,000 people on Medicaid and there is probably another 300,000 or 400,000 who have insurance in the private sector. I think we would all like the system to be working more efficiently. The health care reform, good or bad, that is not nearly as pressing an issue as our current Medicaid program. Health care reform we’ve got to change and get better control of Medicaid.

Question:
I’d like to ask for resource. If you all have a link you could provide of one or more of the medical home models that you think are working effectively. It might give us all a better picture of what those models look like.
Answer: (John Selig)
Oklahoma has some terrific home models. We don’t have one in mind that we want to pursue. We can put some links on the Medicaid website to some various models of medical homes. There are some that focus on particular illnesses and some that focus on high value clients who are 3% of the clients that spend 30% of the money.

Question:
I, as a family member, have a child with autism. Where do I access the service? How do I get into the system? What do I do? Am I going into a provider or going into a medical home? What is your version of accessing the system for long term care client?
Answer: (John Selig)
I don’t think you will access it any differently.
Answer: (Gene Gessow)
One of the things we are trying to ensure is that with every access of the system, you will be directed to the right place, you will get the same answer and the same assistance. Dr. Green’s group has specialists who can help advise you and I am encouraging your cooperation both developmentally and with providers, it should make it easier.

Question:
How do I fit into the medical code situation, as a child with developmental disabilities? What is going to happy to me?
Answer: (Gene Gessow)
As a child with DD who is receiving developmental disabilities services, you are receiving those services, you also have a primary care case manager who talked to your DD provider and made sure you not only
got regular medical services, DD services, that you are being introduced to a new medication, that you may have a bout with asthma, that everyone knew the situation and could treat accordingly.

Comment:
I promise I won’t ask a question but I do need to make a statement and I promise I will make it short. We have been presented with “This is the way we want to go, (we meaning the state), and if we don’t do it that way then all the other options are horrible”. We are basing this plan on some assumptions that many of us aren’t buying into. There is not $50 million or $210 million worth of efficiencies and duplications in the system we’ve got now.
Answer: John Selig
That’s not what we are trying to say. We are trying to bend the cost curve.

Comment:
I understand that. We are trying to bend the cost curve. We all agree with that and we all support that. There are some concepts here worth talking about and worth pursuing. Episodes of care—let’s sit down and talk about them and see what we can do. Partnerships—forcing local doctors, pharmacists, hospitals, therapists, podiatrists, chiropractors, to form all these multiple partnerships it is going to take to provide care and get paid, is something quite frankly, I don’t think anybody in this room is convinced that it is the right thing to do or what we want to do. And the idea that we are going to do all this at once over the next year statewide—we’re not even going to try it someplace to see if it works first—we are going to turn our healthcare system on its butt and hope it works—I have a struggle with that. In the meantime we are not doing anything else to bend the cost curve. Just let me read something to you-I won’t read what it is, I’ll read who it is. Arkansas Medical Society, Community Health Centers of Arkansas, Arkansas Children’s Hospital, Arkansas Hospital Association, Arkansas Academy of Family Physicians, Arkansas Advocates for Children and Families and UAMS, Office of the Chancellor. These were letters written last October, where we all, the majority of healthcare providers in this state, supported enhancing the program that you yourself said works. The Connect care PCCM model that we’ve had for the past 15 years ago works and has been a model for other states, it’s successful, and it’s got buy in from everyone in this room. AFMC made a proposal to you to enhance that program to do many of the things, Gene, you said we want to do. Coordinate care better, cut down on over utilization, all the things that we agree on. Why can’t we look at that as a model, work on that, and look at the other ideas you have on the Episodes of Care and try that somewhere to see if it works before we destroy our whole system?
Answer: (John Selig)
We can work on the PCCM but I think there are interesting ideas in the book. And what we felt we couldn’t do was just take that and two or three others. As we talk strictly about medical homes, I think that some of those ideas that were in that proposal make sense. Whether we can just do that, I don’t think we can get to where we need. Let me also clarify this. We don’t anticipate this change to eliminate the $60 million deficit or the $250 million deficit. That is actually the shortfall we will have if we are able to bend the cost curve. Our concern is, unless we show a real effort to reform the system and bend the cost curve, so we can even get down to those numbers, we won’t be able to go out and raise any revenue. The governor and the legislature will say well “We can’t see that this isn’t a train that is just going to keep running off the track”. We have to show that we are truly changing the system. It’s going to take some real revenue in Arkansas in bending the cost curve because we are trying to bend it down to about 5% growth per year if we can. Even a 5% growth is where those numbers are. I didn’t mean to say that this will get rid of this deficit. You are right; it isn’t going to save $20 million in three years. But we think we can cause people who ultimately put money in the bank to say “You know you look like you are on track and stable and therefore we are willing to help support the system”. I don’t
think we can go in and say we need $250 million two years from now, its $350 next year, $450 the next year. I don’t know how we will be able to sell it. I know, talking to the governor, we can’t sell it to him if we can’t show him we are making significant reform to the system.

Question:
Will it follow the Connect Care then?
Answer: (John Selig)
There is nothing wrong, but just doing that we don’t think will get us anywhere near the kind of reform we need. But that is part of what we are talking about. I think some of those ConnectCare proposals that may be ones we want to incorporate into how we create this, how we strengthen. We just didn’t want to start off nickeling and diming thinking we have made enough of a reform. We felt we had to do something much more significant. In fact I don’t think there is anything wrong with some of those ideas.

Comment: (Janie Huddleston)
I am Janie Huddleston. I am one of 2 deputy directors for the Department and I have 5 divisions. I have DDS, I have Behavioral Health, I have DCO, I have DC Affairs and all of them are working on systems of reform; everybody but Medicaid. And now we are also going to start this with Medicaid so I am going to be 5 for 5. And it’s tough. It’s really tough to get started. After the meeting on Monday I had several people to talk to me, several people send me some ideas about how to get started and I think there are several of you that have unique situations and you need to understand how you are going to fit in with the plan that we have. What we are proposing are 3 different avenues for input and getting your questions answered. First, this set of groups that have persons who want to meet, if you can pull everybody together in the next week or so, we are going to clear our calendars the best we can so we can be available to answer questions. I have already talked with the hospital associations, Gene has already met with a group that is working on adult system of care and answered some the questions they have. That will be one way. The second way is to develop a framework and some questions so that if you want to have your own meeting. Roy Finley at AFMC sent a note and said he would be glad to pull all the children’s service providers together and work through some questions and get them back to you. So we want to provide a framework of questions so you can sit down and start talking about some of those things. Some of you have volunteered already to do that. Thirdly, we need to have some broad discussions, maybe not this large a group, about 3 different areas. The areas of medical care, the area of wellness and then the long term care John Selig was talking about. And that can get us started in the next couple of weeks and then they can move on from there. It is not going to be easy-reform is never easy. I have worked with a lot of you in this room on reform and I know that collectively we can do this. I will be going through the challenge, trying to coordinate and keep the focus moving because of the relationship I already have with a lot of you in this room. Thank you very much for your attendance today. We will use our list to get information out to you and figure out a way to post our updates so you can get those.