

Financing Long Term Services and Supports Plenary: Where Do We Go From Here?

September 3, 2015

CAMILLE DOBSON: Ladies and gentlemen, we're going to go ahead and get started with our closing plenary, so if you could take your seats and turn your attention to the stage, that would be great. So this afternoon we're going to be talking about financing long-term services and supports, where do we go from here. We have a very distinguished panel here to share their thoughts with you. It's meant to be a conversation, so please, we encourage you to send in questions on the app, as you did earlier this week for a number of the plenary sessions. Welcome again, thank you for sticking around, we appreciate it. So without further ado, here are my panelists: This is Gretchen Alkema, who is vice president for policy and communications at the SCAN Foundation. Prior to joining the foundation, she was the 2008/2009 John Hines Health and Aging Policy Fellow and an APSA Congressional Fellow serving in the office of Senator Lincoln. She advised Senator Lincoln on aging, mental health, and long-term care policy during the 2009 healthcare reform debate. She holds a Ph.D. from the Southern California Davis School and was awarded the John A. Harper Doctoral Fellow. She also earned a Master's in social work and is certified as a specialist in aging from the University of Michigan. She started out early in other years as a licensed clinical social worker practicing in government, mental health, residential and post-acute rehab.

To my immediate right is my good friend, Jennifer Burnett, who is currently the Deposit Secretary for the Office of Long-term Living at the Pennsylvania Department of Human Services. Jen was appointed in May 2015 as the Deputy

Secretary following four years where we worked together in the Disabled and Elderly Health program at CMS. Jen was the director and she managed the grant work including the balancing of standard programs. Prior to her appointment at CMS, she came to us from Pennsylvania as the Deputy Secretary for Long-term Living in the Department of Aging and Public Welfare. She served as Chief of Staff in the Office of Long-term Living for four years in the Governor's Office of Healthcare Reform and she has been working for system change in the aging and disability world for years. She's been a consultant doing grants management, she consulted for a Commonwealth of Pennsylvania, the state wide Living Independent Council in Maryland and Pennsylvania, AAPD, and ADA Watch, and has been involved in advocacy with older Pennsylvanians, including the passage of the Older Adults Protective Services Law. I didn't realize when we did this in alphabetical order we were going to be girls and boys. That wasn't intentional.

But as we turn to the gentleman to my left, Howard Gleckman, a Senior Fellow where he affiliates with the tax policy center and the program on retirement policy. He is also an author of *Caring for Our Parents* and is a columnist on long-term care issues on Forbes.com, where I've personally read lots of your writing, Howard. He's also the editor of the Urban Booking Tax Policy Center's fiscal policy blog tax. He is a tough convener of the Long-term Care Financing Collaborative, which is a group of policy experts working to design systems of financing for LTSS, he writes and speaks frequently on long-term care, he's a visiting fellow at Boston College, a senior correspondent in the Washington Bureau of Business Week, an Advice Chair of the Board of Trustees of Suburban Hospital, a trustee of the Armstrong Institute for patient safety and quality at Johns Hopkins, and a board

member of the Jewish Council for Aging of Greater Washington.

And last but certainly not least, my former boss, Dennis Smith, who is currently a Principal in the Washington D.C. Office of Dentons, where his practice focuses on state policy. He has been in the private sector, where he most recently served as Secretary of the Department of Health Services for the State of Wisconsin. In July of 2001, he was appointed by President George W. Bush to serve for CMS, where he served until 2008 and during his tenure, he was the Lead Federal Negotiator for waivers that redesigned Medicaid programs in the state, including New York. He also served as acting administrator at CMS for 7 years and before coming to CMS, he was the Medicaid Director for Commonwealth of Virginia, Chief of Planning for the California Department of Developmental Services, easy for me to say, served in the House and the Senate as a Professional Staff Member on the Senate Committee on Finance, and he was instrumental in creating the State Children's Health Insurance Program and other landmark legislation. Dennis has worked in his career to expand health insurance coverage and lower costs by modernizing Medicaid and Medicare, state flexibility, and individual choice and responsibilities, and he is also a member of the Long-term Care Financing Collaborative.

So we have lots of experts on the stage today. First, I think it would be interesting for people to understand what the Long-term Care Financing Collaborative is, so I wondered if either Howard or Dennis, if you could talk about the collaborative and what it's been doing.

HOWARD GLECKMAN: Let me start and then I'll let Gretchen or Dennis jump in.

So to give you a little bit of history, after the demise of the class act, there was a lot

of discussion in Washington among think tank people and advocates and the industry about what we could do to try to revive the issue of long-term financing, we were very afraid that after the class crashed, that no one would want to deal with this issue for years. We all realized that was a very dangerous outcome, so the collaborative is a number of non-governmental groups that have gotten together to start to think about policy options for financing long-term care. The bipartisan policy center, which some of you may know, is a group of former Democrat and Republican members of Congress, Governor Tommy Thompson and some other senior people are also doing their own project on long-term care financing and delivery. The Leading Age, the group that represents not-for-profit in the community is doing a project of its own. The collaborative serves an ad hoc group not associated with any arranged organization like that. What we did is we brought together people from the aging community, the disability community, providers, people from the insurance industry, conservatives, liberals, really as broad a group as we could think of, people had really two things in common, one of them was that we all really cared passionately about this issue, and the other is that we felt we could work together, people were not drawing lines in the sand and using a collaborative facilitated process. We've been working for the last number of years try to develop a program. In July we put out a report on delivery, even though delivery is not our primary focus. We realized you cannot define a financing program unless you need that it be finance, so we designed a framework for delivery, not a plan but more of a framework and I hope by the end of the year we'll have some recommendations on financing.

CAMILLE DOBSON: Dennis, any thoughts of your work with the collaborative?

DENNIS SMITH: It's great to be here with you this afternoon, it was a combination of people that you generally would not get in the same room in Washington. It truly was collaborative in that people would listen to each other, they weren't just talking, they were listening as well and it's been a tremendous experience for me as people put their ideas on the table: what is most important to them, what are they most concerned about, where are some of the gaps in the financing issue. We all know it was going to be a difficult one to get a handle on, so part of the work of what has been done is to really try to get the baseline: what do we know as a society, we are aging, the demand, the future demands, the change in the family unit, the role that families play as caretaker, well, that's likely going to change and it's changing pretty dramatically.

I think the fascinating part, and I think a lot of the way weight that this group brings, is that it is such a diverse group of people and to be able to come to out in July, as Howard mentioned, with our vision and our principle understanding that a lot of the long-term services and supports are non-medical in nature. Talking about how to start making it and supporting states that want to get funding streams for housing and social services and all of the things to support the individual and, you know, we've made a great deal of progress since the first home and community-based waivers started with little Katie Beckett. We've come a long way, but we as a group understand we still have a long way to go.

CAMILLE DOBSON: That's right. So Gretchen, I know that SCAN is passionate about services for older adults and obviously, long-term services and supports as they age, what kind of perspective do you bring from the SCAN Foundation about those issues?

GRETCHEN ALEKMA: Certainly, Camille, thank you so much for having us here today, and a thank you to Martha and the team for bringing the visibility up on long-term care financing to this great audience. So the SCAN Foundation focuses as a public charity in Long Beach, California. We focus on some federal issues that have salience of how do we look towards the future for all of us who are working today, how might we finance the future of our own long-term care needs, in addition to looking at how does the delivery system look at those who have needs at this present moment. So specifically with long-term care financing we've been doing some aspects of this work really since the foundation was created back in the mid-2000s. My boss, Dr. Bruce Churnonf ended up serving as the chair of the Long-term Care Commission, created right after the removal of class from the Affordable Care Act and through a very, very short process that happened in December of 2013, a number of recommendations were put forward about how can we as Americans really move forward to a high-performing system of long-term services and supports including service delivery, workforce and finance. When the dialogue was happening with the bipartisan group of commissioners about the issues, people across the board had really great ideas about how might we finance issues of long-term care needs in the future. The challenge was and is that no one, and that was across the board, regardless of political perspective had numbers to back up what would be the impact of those long-term care financing options, how much would they cost individuals or the government, and how much uptake might there be to address people's needs. So as the commission revolved by not making any specific recommendations on that front, we took it back into the foundation and thought there needs to be even more robust information about how might we cost out what long-term care financing

options would be in the future across this wide array of choices of how one might do that. We were delighted to be able to partner with AARP and Leading Age to finance some work being done by The Urban Institute. At that time, The Urban Institute colleagues have this really powerful simulation model that can project information out into the future about policy options called Dynasim, and I think some of my colleagues are still here in the audience, and they were gracious and really having the foresight to step forward and put some more information and more data into that simulation model so that it would include retirement savings, healthcare information, and supports to create this really raw dataset to understand what it might look like in costs down the road to the urban steam work with partners who are helping provide some information from the long-term care financing crises that help understand this landscape further. Our anticipation is that we'll be able to share with you in the fall some numbers about some high level policy options to address America's long-term care financing crisis and it's been fantastic to work with groups to seed in the ideas about the high level policy option. It's really a first glimpse into a new way of looking at how we write finance care, what might be the impact on governments, and on individuals and on systems in doing that. So it's a first look at hitting the reset button for a policy landscape that can come forward, and we've been delighted to be a prepare in this process.

CAMILLE DOBSON: That's all wonderful if you can get all of the good data, so that sounds like it could work. We'll be keeping our eye out, as it is coming this fall. I think we could agree in large part, long-term services supports are funded by the Medicaid program, which is not what it's intended to be. It wasn't set out to be that way, people -- I'm sure you've all had that experiences. When my family members

asked me about nursing facility care or being able to stay at home when they need support, well surely Medicare pays for that, right?

No. Medicaid -- Medicare doesn't pay for that.

What do you mean it doesn't?

That's the insurance program for older adult, right for the elderly how does it not pay for that? So one of the things that I think might help move the dialogue in this conversation forward is to get that information out to people to create a sense of urgency. Are there ways that those of us here in the room could continue to pound that message forward into the true financing recognition and the entitlement benefit that most people come to expect in Medicare?

JENNIFER BURNETT: We've been funding a poll that does national level polling and this poll is particularly about American's perception and understanding of aging and long-term care. What's been fascinating is that there is always the question of, does Medicare pay for long-term care? Previous polls have looked at that as a generally no response, we added in the -- yes/no response, we added in the, I don't know, and the largest percentage underneath folk's response is, I don't know, which actually speaks to a huge knowledge gap that we have in America. No one's square foot confident about whether it's a yes or no and it's a good opportunity for all of us to continue to educate folks about what Medicare does cover and doesn't cover and how families can start to have conversations about what they want as they grow older. So it's an amazing report, longtermcarepoll.org, with lots of data points in it for you all to use and there's been a number of AP stories out about that, so please check that out.

CAMILLE DOBSON: Anybody else want to weigh in on the education of the

public about long-term care.

HOWARD GLECKMAN: Medicaid is not the biggest pair, that is us, and the somewhat surprising results of that is that almost half of long-term services supports particularly at the DADL need level is actually paid by the families. So the story is people pay out of pocket until they go broke and then they turn to Medicaid. It's really true, I do community talk, I talk to mostly adult children of older Americans about this all the time and one of the first questions I ask is who pays for this? Who you do think pays, and they all say Medicare or they say they don't know. But nobody -- nobody says Medicaid.

GRETCHEN ALEKMA: Well, I'm going to talk briefly about Medicaid, I agree that we, that is the American public, pays for long-term care both in terms of the record work that caregivers do, that's a great provider for long-term care, but Medicaid itself is the safety net. As Allen Weil said many years ago, it really is the safety net for people as they spend down and lose their lifetime savings. Medicaid becomes that and in fact, there are elder lawyers all over the country who know this and advise people on how to provide, you know, to hide assets so they can gain access to Medicaid but we're not there to talk about that. I would say that Medicaid is the largest insurance payer in America in terms of long-term care and people don't know about that. I have to say SCAN has on public radio now has a -- it's the first time I've heard on the radio any talk about long-term age, it's not really advertising because it's on public radio, it's not advertising. And they talk about SCAN and I think people need to hear that more and more and that's where states can play a role. Every Medicaid program is a little different but I do think states have an opportunity to follow up on what Camille's asking about, which is how did we educate people. I

love the idea of supporting public radio and talking about long-term care. But states also have the state health insurance program, the SHIP program, which is run by different agencies in different states. Pennsylvania, which is where I'm from, it's in our department of aging. It's a really, really great program that teaches people about Medicare and I can see this and when I talk to SHIP counselors and there's a network of about 600 of them around the state. They're very proud of their work, every year they have to go through a tremendous amount of training so as a state, I'm very interested in how we engage our SHIP program, even though I come from a different department. I'm the department of how many services, I'm always talking with our Department of Aging about how to better engage our SHIP program. Financing is something that a lot of times people, in our field interested in policy and social work and the direct services, don't think about the financing aspects of it. In my current position, I know that I have to think about it every day, part of what I did, sort of strategically, I think, was to make sure that my Chief Financial Officer came to this conference, so she could be hearing about all the different programs and it isn't just kind of like paying the bills, but it is really understanding that nexus between the finance and the program, so I think that's really important. But SHIP, I think and SCAN are my two things that at least I have observed as resources for getting the word out, Camille.

CAMILLE DOBSON: All right, great.

DENNIS SMITH: And areas that we know in our work so far has a little bit of a hole in it because the impetus and the models have been on this 65 year plus population when Medicaid is involved. A substantial percentage of money and the people we serve with long-term services and supports are those with disabilities and

an individual who's relying on support and the Medicaid program on the basis of the disability is going to be doing that for a longer period of time. So again, one of the discussions, and I want to acknowledge another former Medicaid director, Mike Fogerty from Oklahoma, a member of the collaborative, what we sort of did early on is give a Medicaid 101 to the members of the collaborative because the emphasis has so far been on the elderly population what is the world of Medicare. We had some great discussions and one of our subgroups, in particular, that's a low-income population, what does Medicaid look like today, what does it do, how is it organized. So again we had a lot of recognition about leveling the playing field about institutional and noninstitutional care, building in the support for self-direction, sort of as a -- not as a waiver, not an afterthought but as an integral thought.

So Medicaid, I think the tremendous work that it does within a framework though that was built a long time ago. Sometimes it's hard to shoe horn in what we want to do in a shoe horn. In what we want to do in the constructs of the immediate data structure and even helping the waiver services, still as an element of a medical component to that versus just the recognition to say, you know, we want to build something around an individual. This means to be person-centered means that it's not a cookie-cutter approach, that it does mean that you're going to provide a service just for Dennis or Camille or Howard that is different than other people, and that's to some extent still a hard concept to get people's head around that it's not uniform, it's person centered. How do we develop these programs and supporting individuals and again, the concept to say well, how can supportive employment ever be medically necessary? You move back in and you run into a bit of a brick wall and -- but then we find ourselves, our innovation of getting around the federal rules, we ought to be

making it a lot easier. As I said early on, what a person needs, what a person wants sometimes, if you fund what a person wants is a lot more cost effective in the long run, because the longer that you can keep the Dennis at home in the community the better it is. Sn individual's wants are as different as each one of us sitting up here, so how do we build that support around Dennis and his family, keeping them together and in the community? One of the things that again my experience in Wisconsin, is how many home and community-based services were layered into Medicaid over time. You still had a lot of distance or reverse incentives in that program, when I was in Virginia, the county-based community services board who had put up the local dollars before Medicaid could be tapped into, they then saw that as saying okay, well, that revenue should come back to us as the county, and there is an incentive to build a plan of care that was delivering as many services as possible. They're looking at your means, we're looking at your weaknesses, your needs, we are looking at what you're missing and starting to turn that around and say actually, we're going look at your strengths and how do we build after that to give you greater control over what you want, your idea of what you're looking for to living in your own home, the community, what do you need to do that. Working off your strengths that you can go to work, you have the will to work, all right and then we have the penalty of saying don't work so much, though, and again, that was an example of the great discussions that we've had in this group of saying you're right, we are tied back to a model that is of day's long gone by so how do we lean towards the system we want without bankrupting everybody at the same time.

CAMILLE DOBSON: Well, that's a great segue, Dennis, thank you.

[Applause]

CAMILLE DOBSON: Preaching to the choir here, it's a home community-based services conference, we've spent four days talking about person-centered, been around what they want and their strengths, you just got here, so yeah. So one of the questions that's always puzzled me and I know Martha wanted to throw out to the group is why there's such low pickup rate for private long-term care insurance, you know, we think about car insurance and life insurance and health insurance mostly through our work or from, you know, the exchanges if you don't have the base of coverage, but there isn't the same sort of specifications or inclination for long-term care insurance that would cover those at the end, and why, why you do think that is? Howard, so the founders would look at this and say there's a classic example of a failure, there are demands on the supply side and demands on the consumer side, the short answer is because it's too expensive. Premiums are now for somebody in their '60s for a typical policy somewhere in the neighborhood of \$3,000 per year and people just don't want to spend that kind of money. It's complicated, people don't understand how the insurance works. There are real issues about underwriting that are getting increasingly difficult, probably 20 to 30% of people who do want to buy it can't because they're either written out or the insurance companies are actually being more strict about underwriting than they used to be. Then on the flip side, from the industry side, there have been a number of serious challenges. They don't know what to do about what actuaries like to call a tail risk, those relatively few people who need care for a long, long time, the consequence of this has been two-fold, one is premiums go up but I'll tell you something, people want to blame the insurance interest for this. Genworth, the longest seller in 2014 had to tell investors that it was taking a one billion dollar charge, B with a B because it had underestimated the cost

of claims for people who already hold policies. So it's not a surprise they're trying tomorrow raise premiums because they're trying to recoup some of this morning. The ability to understand the long-term care risk is that insurance companies have abandoned the business, there used to be hundreds of people selling this, now there are 10, they were selling 750,000 policies a year now they're selling about 250,000, so this is an interest that has a real problem and the last thing I'll say is it's America and we don't have foresight. We don't like to think about the future, we especially don't like to think about the future when it means health care and nursing home and assisted living facilities. We don't do that and to put all this together and it creating a very serious problem.

CAMILLE DOBSON: And specifically, about people not thinking about their future, some of the questions in the AP poll that was talked about earlier, two things that stand out to me. First of all, this year we actually had members of respondents believe that somebody in their family or their friend network would have a daily living need in the next five years which seems just mind boggling given how the population is aging. So have you that and then the other question that was well, a family member does have a need they think somebody else is going to take care of it in their family, and I mean, right, I just looked at that and think with the climbing numbers of children historically over trends, baby boomers have less kids and who do they think is going to pick up that slack but they think oh no, somebody else in my name is going to do it, so even when the issue starts to get close to people, folks are finding ways of pushing it away and pushing it away and really believing that this may happen to my neighborhood, but boy, it sure ain't going to happen to me.

DENNIS SMITH: Let me add to what Howard said when an elderly person or

couple is looking at that. People are and their focus, in many respects, is on their acute care needs that, you know, they're buying supplemental insurance already for their acute care, and that's costing them X dollars a month and they're looking at another \$3,000 premium. And they say no. Who should be saying mom, dad, I'd be happy to pay that premium, because what they're really doing is protecting their own inheritance but we don't market long-term care that way. But that's the reality of the situation. Again, it's estate planning. As a former Medicaid director, you know, all of this sort of gave me a little bit of heartburn, but the first thing you say is you want to leave something for your children and grandchildren, right, you're not in here to protect asset assets so can you get on Medicaid, you're here because you want to give your children and grandchildren something. So I think we need to get the kids and the grandkids to step up to the plate a little bit, to get them to understand really what is in their interest, because I mean, a \$3,000 a year premium, that's actually pretty doable, especially if there are, you know, 8, kids, we could have handled that.

CAMILLE DOBSON: I only have somebody else to split it with, Dennis, so I don't know about that, but I agree with you, nobody wants to -- there's so many problems with the conversation about planning for what is an unpleasant thing to think about, you know. So we've been having this theme through plenaries about pixie dust, and we've been asking people if you had pixie dust, right, what would you go back and do or could you do something differently. So I think that what I would ask here is if you could go back and sort of redo the Class Act, if you could do back and fix what was broken in that, is there anything you think maybe should be done differently or could have been done differently to end up in a different place so that we would have sort of a Federal Long-term Care program? Anybody want to take that or we

can just proof off to another topic.

DENNIS SMITH: I'm going to sort of take the pixie dust in a different direction and taking it forward and look at it and see where can we go and what does mean as we move forward to long-term care financing solutions given where we are. We take pixie dust and change things around, we might not have some of the things that have helped the larger healthcare delivery conduct such as the Affordable Healthcare Act, to looking forward, Gretchen's pixie dust is that folks in this room and many, many, many others build on the great work that these collaborative groups, AARP, Leading Age, decide aggregate care. Many different voices coming to the table with solutions see to the policy modeling work that comes out later this fall. We can see the threads of doing next step works to get to in a very short period of time, a suite of policy options that will actually address a broad range of needs both for mainstream people who are older and look at this long-term financing as part of the financing package as well as a renewed way of looking at this. I want to have supports today and into the future and that's about take the creative energy of all of us here and frankly the willingness to move forward and the challenge of political will over a really, really difficult issue is always a complicated one. But we can look at the most expensive option that we have right now. So the most expensive option is literally doing nothing and that's expensive for people, for families, for communities, for states, and for the Federal government, and that will pass every single resource we have in frankly ways we can't even realize at this moment. So that's my pixie dust, it is that we march forward and that everybody benefits everyone personally and from a societal assistant standpoint.

CAMILLE DOBSON: A couple lessons that people did learn from the class act is

there's probably not a single solution for older people and for younger people with disabilities, this probably requires multiple solutions and one of the things the class tried to do was kind of roll it up into one idea and it just didn't work. So Dennis alluded to this before and I think it's a very important issue. We are thinking about this at the collaborative and I think it's fair to say the other groups as well, not just as an older person's issue, we're thinking about this as an issue that affects the other people with disabilities and the many disability issues within that, whether it's physical disabilities or developmental disabilities or the aging health issues. there's a whole sets of supports and service issues for that group and then there's a separate set of supports and services issues for older people. And one of the things we're trying to do is unpack all that and see if we can find solutions that work for both groups. Dennis alluded to one of the big issues, as you think about a solution for younger people with disabilities, you want that that solution makes it possible for them to continue to work if they want to and if they can. When you're thinking about 85-year-olds, maybe work is not as important a factor, so you do have to think about different solutions because they're in some ways different problems.

DENNIS SMITH : Yeah, I'm going to take some of Gretchen's Pixie dust and just put my State hat on to talk about the role of states in this whole question of, you know, without the class act, what do we do moving forward? And from my perspective, I think states have a role in that being the largest public payor, or the largest insurance program for Medicaid, is the largest insurance payor of long-term care, I think that puts states in a great leadership role, a potential good leadership role getting their systems to be highly operational, efficient, meeting people's needs, person centered, I can't stress that enough. I think Dennis is right on the market when

he talks about person-centeredness. If you start with the person and in was speaking to mention mentor Kathleen Klineman, who may still be in the office earlier today, who reminds me that people don't want aides coming into their house, they get long-term care, something that budget offices talk about. If you offer it, people will come out of the woodwork and it will bust your budget, people don't want long-term care, they used to because it's a fact that much of their life at the time that they seek out long-term care, people don't enjoy having an aide coming into their house, they live with it. It's a fact of life. So I think there is a real opportunity for states to make improvements. Going back to what Dennis said, good person-centeredness, maybe they'll need help in coaching and getting there but I think if we really build programs and states aren't there yet, some states are, but most of them aren't, you will be able to build systems that meet the needs of families. As Howard was talking about the different population groups, as this long-term care and financing discussion hit, it fits happiness and the entire American public, to be frank, it's everybody's responsibility. You guys already know it is, and it's your world, everybody sitting in this audience touches on this either in their personal life or their career. But when we go outside and on the streets here, people don't understand or know much about it, unless it's in their life already. Once it's in your life, it doesn't go away, in fact, sometimes you become an advocate for long-term care, but I really think that states have an opportunity to provide solid leadership and if they can really at least to some extent be a leader in the state and get their state financing in line, and get their program to be something that is something that people want to participate in, and are supported by; I think those dollars will go further. And I think we miss the mark when we have a really more institutional bias which my state has, by the way, I think we really miss

the mark. I'm not saying that nursing homes are not completely out of the picture they're an important part of the long-term care continuum, but I think more people, many more people can live in the community and we can do a better job both financing-wise but also in terms of what the person wants. So it shouldn't be the first option. That's the conundrum the Medicaid and the institutional benefit.

CAMILLE DOBSON : Are you talking about the bias?

JENNIFER BURNETT: I am convinced, they started talking about housing. I believe the fact that we pay for housing in institutional settings as opposed to -- and we don't pay for it when somebody's at home we can't even touch it-- Medicaid I'm talking about, I think that is the fundamental institutional bias, so I just had to get on my soapbox for a minute.

[Applause]

CAMILLE DOBSON : That would be some pixie dust.

JENNIFER BURNETT: That is Jennifer's Pixie dust.

CAMILLE DOBSON: We have 15 minutes left, and I would be remiss, one of the things that Martha really wanted to throw out to the panel to talk about is potentially a Part E added to Medicare as a Long-term Services and Supports option, either through the traditional way Medicare has done or a more profitized sort of person-driven approach -- is that in the reality of the conversation and the option.

The part about the modeling work and some of you may have seen that, LeadingAge put out a report in the end of 2013 called their "Pathways Report" and what they did in that report, it was following the commission's work, is basically articulate what are the kind of big buckets of policy options that folks are considering all the way from not considering anything at all, which is the status quo,

what we have today, to things looking at like smaller, private market insurance reform. So not fundamentally changing the market but doing some tweaks around the edges then looking at bigger buckets of insurance coverage, and front lined coverage. Essentially what Class was looking at doing, then the next one looking at more of a backend or catastrophic coverage that many people think about as Medicaid. But fundamentally we don't fund Medicaid like an insurance model, we pay it that way but we don't fund that way. As to thinking how to do a truly catastrophic model and then putting the front and back together to a much larger social insurance option, which is essentially what the Medicare party conversation is about-- what's the modeling that we are going to be working towards and having out in the fall will array these five large buckets of options as well as some kind of tweaks and some Medicaid reforms. Essentially, we'll be able to have a comparable discussion of these big buckets, and what we know about for each bucket, who uptakes that bucket, what kinds of people does it touch, how many kinds of people does it touch, and what essentially are the costs of that, more of an apples to apples comparison. I'll make one more plug for the model. What I love about the model is that it brings all of the components together so we can do that apples to apples comparison, which is confidence in the model itself so we don't have all sorts of different groups going to out there and making up their special new modeling techniques which then creates opportunities for policy makers to argue about the model and assumptions as opposed to the policies that we're testing through the model, which is where all the argument should be as hearing the options not the base model itself. So we'll essentially have numbers around the Medicare party concept, the social insurance concept relative to front and back end, private market reform et cetera,. So Howard,

do you want to add in that?

HOWARD GLECKMAN: That's all absolutely right, I think there are a couple of challenges, let me back up, an insurance solution has to be part of this but there are a couple of big issues, do you want Medicare to be the platform and I'll let Dennis talk about this because he's been very outspoken about this. But do you want immediate care to be the platform and you can think about possible pros and cons of that, the other issue is we've got to be politically realistic about it. We're not going to have a mandated universal social insurance program, you look at the politics in the United States today, that's just not in the pie, so an interesting question to ask is: Can you create a package of incentives that get a program close to the kind of enrollment you get with a mandate without it actually being a mandate? Medicaid Part B is not a mandate, you don't have to enroll in Part B even though 95% of people do, you don't need enroll in part D even though most everyone does, so you've got to be very careful about the language. Is it social insurance? Is it universal mandated or is it voluntary with lots of incentives? But those are the kinds of issues that we're struggling with and the kinds of issues that make this very hard, that we should hear from Dennis.

DENNIS SMITH: Well, I promised Martha I was going to behave myself.

CAMILLE DOBSON: But she's not here. I will report back, though, so go forward.

DENNIS SMITH: Yeah, I think it needs to be looked at on the other hand which is how is Medicare financed today. So if people are saying part E to Medicare, well, does that look like part A being paid through the payroll tax? Which quite frankly is too late for baby boomers which means the entire burden would fall on the next generation. so that needs to be part of the discussion, I think, if you're going to add a

benefited Medicare. I think it's appropriate and necessary to say well, okay, who is really going to pay for it? Are you going pay for it kind of like Part B, where you have the premium? And general fund financing? So one thing leads to another when you say Medicare part E, I think the biggest challenge and the biggest pushback are two-fold. One likely will be that the financing falls to the next generation and we know that number of working beneficiaries have been falling through the years, this is part of the challenge Medicare already faces-- its that we've got a few more than three workers per beneficiary now, that will soon drop to two workers per beneficiary. So what is the burden on the workers because at that point, it becomes a pay as you go system, it truly is a pay as you go system at that point in time and is that a burden that the next generation can really handle when you for every two people you're supporting another person?

The second part, which again, I sort of scratch my head at, especially with people in the disability community, why would they even think of putting it into Medicare when how long did you fight the homebound rule for a wheelchair? Medicare knows -- nobody wants to answer. Medicare knows acute care services. It has only been a little bit more than a decade that prescription drugs were even added as a benefit to the Medicare program, if you are looking for innovation and creativity and person-centeredness, maybe Medicare is not the place that you look.

CAMILLE DOBSON: You're getting some laughs in the back. Maybe. Well, there's innovation, Dennis it's just on the delivery system side of Medicare not necessarily in the insurance structure, I mean, there's lots of creativity there but I think the insurance -- the structure itself kind of exists as it does right now and that, you know, looking at where are those creativities and how the delivery system works in

Medicare today. I would say that there's actually a lot of opportunity for places, like in accountable care organizations, and some of the demos being a lot more creative in how they think about care coordination and care transition than we've seen, you know, historically, so I mean, you're talking about kind of a different place in terms of new insurance design. I think we have a great opportunity to really push what the delivery system can do right now in various flexibilities that alternative payment models are doing but it's not going to be full care for a long period of time. It would really go a long way to help older people and their families and younger people with disabilities have access to Medicare look at new ways of how they might get their needs met over the long haul using that care coordination opportunity that exists.

CAMILLE DOBSON: In 1965, the Mustang was the coolest car the world.

DENNIS SMITH: That was a great car.

CAMILLE DOBSON: But the problem is it's become a little bit obsolete and what you would have to do to make a Mustang work in 2015 is, you know, give it new brakes and give it seat belts and get rid of the carburetor and put in a computer and by the time you were done, you wouldn't have a 1965 Ford Mustang any more, you would just have the name plate and the cool little car but you wouldn't have much else. And there is an issue here about Medicare, the kinds of things that Gretchen is talking about, you are trying to fit a square peg into a round hole. You have a structure that didn't contemplate in 1965 chronic care, to say nothing of long-term care, and we have to really struggle to try to make these innovations fit into a system that it was never really designed for and that's a challenge. That raises a question about do you want to keep adding onto it or try something else?

DENNIS SMITH: I think it is critical that we do push for greater coordination and

integration between the acute care side and the long-term services and support side because there's still the game of hot potato and tossing it into the other guy's lap. And on the other hand, we know the chronic care conditions related to diabetes and are related to obesity. The more chronic care conditions that you have, the more likely you are going to be in need of long-term services and supports. So by all means, we need to be spreading that message, in my estimations, anyway, that there is a relationship there that people need to be more aware of. Doing a better job of coordinating those services, so the question becomes well, who do you give that to? Who do you give the job or the incentive to, who has the incentive to make both of these two great big programs work together better? And that's probably another discussion.

[Laughter]

JENNIFER BURNETT: Speaking as a state, I would love a Medicare part E but I understand that there are challenges in terms of being a Ford 1965 Mustang, which my aunt had, and it was candy apple red and I loved it. But I think Dennis is right on the money when he talks about the coordination and I think right now that structure-- I love the idea of a federal solution and I think a federal solution is really needed in terms of funding it--how you pay for is a whole other story but I don't want to let go of the idea that Medicare and Medicaid have to work together in more of a coordinated way, that disconnect, that challenge, and the duals office in CMS, the duals office since the Affordable Care Act has passed has been grappling with this in states all over the country, grappling with the whole broken Medicare system. But I don't really like dissing Medicare because I think it has done such an incredible job of keeping older people healthy and active in their community but I think we do need

fix with it. And it's not going to be an easy fix. To your question of who does this, I think some states could do it, but I also think some states would be happy to do it, and I'm not sure, is that Vanessa over there?

CAMILLE DOBSON : She is.

JENNIFER BURNETT: Okay. Okay. Vanessa knows more than anyone how important it is for states and Medicare to work together and to coordinate and that's very, very difficult in the current structure of Medicare. So I mean, I think there's opportunity here, I don't know about the part E, maybe with some pixie dust, it would work, but I think it's a conversation that has to continue, because right now, these two silos are not working well together and they're not doing a good job of real long-term care and delivery of service that meets people's needs.

CAMILLE DOBSON: Well, I could not think of a better way to end this conversation. We have flown, the hour has just flown by, and we are at the end of our time today. Please give a very, very warm round of applause for our panelists.

[Applause]

Thank you to Gretchen, Jen, Howard, and Dennis for a very thought provoking sets of confidences. I think it's time for us to bring the over there to where we are today because it's a really critical part for moving us forward, so thank y'all very much. We have our vice president, Gary, yes he is going to wrap us up and send us on our way since our president, Jay Bulot, had to be on a plane back to Georgia. Did everybody enjoy the conference? Is anybody tired both mentally and physically? Anyway we want to thank you for being here at the conference and hope you will come back next year. Do you all plan to come back? We plan to be bigger and better and the best part of the conference is hearing about all of the innovative

programming and strategies taking place all over the nation. So be productive and go forth and do great things and then come back and brag about them next year so we can replicate them. Thank you, safe travels to all of you, and we'll see you very soon!

[Applause]

Oh, let me say one more thing, I wanted to just lastly, I wanted to make sure we acknowledge all of the sponsors, I also quantity to acknowledge the hotel and staff, this has been a wonderful venue and we feel very well taken care of, thank you so much! Thank you so much!

[Applause]

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