Maureen Pero, Vice President, Federal Affairs & Policy
CareSource Management Group

"Voice of the Customer/Patient in the Paradigm of Person-Directed Mobility and Healthcare"

Remarks at the "Rides to Wellness" Summit
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Good afternoon. Good afternoon.

I don't know what he had for lunch, but I want some of it. Hello, I'm Maureen Pero and I am so pleased to be here today. It's very unusual, I'll be honest, for a Medicaid managed care organization to be invited to come in and talk with individuals in the transit community. So I went out into the organization and I tried to find someone else who had had some similar conversations, and unfortunately, I couldn't find any.

So thank you and I'm here today to give a little bit of a different perspective. I want to represent our members. I work for a wonderful nonprofit similar to Kaiser Permanente. I'm fortunate enough to work for an organization that is mission-based. We have a focus on serving the vulnerable populations and giving them access to healthcare. We're the largest Medicaid managed care organization in Ohio, but in addition, with the Affordable Care Act, we've also branched out and we're able to serve a continuum of government program consumers, and that includes both the TANF population, which is a lot, of course, of our pregnant moms and our babies; our aged, blind, and disabled; the Medicare and Medicare and Medicaid eligibles, the dual eligible program; Ohio is one of the demonstration States; and then, of course, we're on the Marketplace.

On the Marketplace we have designed our plans to appeal to individuals who are about 250% of the FPL and below. The reason we've done that is so that we can continue to serve our members and their families as they work through different eligibility levels along that continuum of their lives. As a company, we–we're about a seven billion dollar company, so compared to Kaiser, we're small dog. But we do service Ohio, Kentucky, and Indiana, and I'm proud to say that we have had similar experiences in all of those States in terms of working for the lower income and more vulnerable populations.

Just to set the–a level playing field here, I know some of you are in the Medicaid arena but many of you are not. You're in the transportation world. So I think it's important that you understand how the transportation benefit intersects with the Medicaid program. As a Medicaid managed care organization, we are at risk for our members. What that means is we enter into a contract with the States, and the States pay us a per member per month fee to handle our members. That includes all of the benefits that our members need, whether they need a ton of benefits or whether they need no benefits.

We handle that continuum and we're paid that way. So how does transportation fit into that? Transportation is considered part of the core benefits of the Medicaid program, but it varies in terms of how States interpret the importance of transportation for that benefit.

For example, in Ohio we are, in our provider agreement, we're mandated to provide transportation if it's required for a medically necessary procedure over 30 miles from home. So you can see that takes out an awful lot of transportation needs for our members, especially because Ohio is–has a lot of urban areas where people may live close but they can't access healthcare. So living within 30 miles, from our perspective, does not equate to access. As a company, we provide an enhanced benefit where we provide transportation up to 30 one-way trips to services. In addition, we focus on particular needs of our population and then can authorize more.

But when you think about a partnership from a Transit Authority with someone who's a Medicaid provider, you need to think about what the Medicaid provider is being incentivized to do to think about how do you fit into that equation and how can you partner with us to make sure that our members, especially those that are the most vulnerable, do have true access and that they have choice in how they access for their healthcare services? So it's just a different perspective in terms of how we're paid and how we're incentivized as a company.

At CareSource we use a model of care progression and we risk stratify our population and we really service on the low end of the continuum individuals who are primarily the healthy: the healthy kids, the healthy moms. And as they progress through the continuum, we look at really what are their healthcare needs? And as you progress on all the way up to an extreme complex member, the costs also equate as you move along that continuum. So, part of our goal as a managed care organization and as a steward of the State and the population health of our State, we try to target and focus on the individuals who most need that care with those precious Medicaid dollars that are out there. We focus on that in terms of increasing our care coordination.

We have navigators who are out in all of our communities looking for other community resources to partner with our healthcare services, and trying to stabilize people where they are, improve their health wherever possible, and prevent them from moving along that continuum into a more unhealthy state. We also share the Triple Aim goals. Our–we are incentivized to have a healthy population. We're incentivized to provide quality care, but overall, from our States–and right now, Kentucky, Indiana, and Ohio I would characterize as red States–the overall goal for the Medicaid program is to reduce cost and to demonstrate the ability to reduce those costs. I'll tell you, one of the biggest challenges we face is that when a State runs into a cost problem with the Medicaid program, the first thing they look at cutting are enhanced benefits that are not directly tied to care. So what's the first thing that goes or what's the first benefit that we have to struggle to decide can we afford to cover it on our own? It's transportation.

CareSource is also embarking on working with our members to address some of the challenges that they face. We call them their life services. What it is that they face in order to make them healthy and have the ability to access healthcare services is social determinants, right of health. And what we find–I was so anxious or so excited when I heard you talk about your Nancy–your Nancy is our member. That's who we serve day in and day out. And when we go into homes with our navigators and we want to find out why aren't you at your doctor appointment, when we find out there's no food in their refrigerator then what we have to focus on is how do we get food in that refrigerator first? And then focus on how do we get them to focus on their healthcare?

So we've embarked on life services where, based on the continuum of where they are in our products, whether they're an exchange member, they're on the Marketplace, they can afford part of their premium, generally have less need for some of the life services; down to our most vulnerable Medicaid and dual eligible members who often need food, safety, access to behavioral health services. We're also doing JobConnect. With JobConnect we're focusing on how do we connect those members that we serve who would like to have economic stability and access to jobs? So we've partnered with some of our employers and we're going through job training and it's voluntary with our members. We're notifying them to say, "Hey, are you interested?" We've talked to X job or X company. They've got 12,000 jobs coming up. How can we get you hooked up? And we've had overwhelming support with members coming forward, voluntarily saying, "I want to have job training. I need a suit for an interview. Can you hook me up with an agency?"

One of the reasons I'm sharing all of this is that through these expanded services we're finding that transportation is a barrier. It's a barrier not only for access to healthcare, but it's a barrier to achieving that economic stability to getting to that job interview, to getting their children into childcare before they go to the job interview. It is a barrier. So I'm also here to hopefully come up with some innovative ideas on how we can better partner with the transportation providers in order to address some of these barriers.

This just talks a little bit about why is it important? It's required. But what's required is the minimum, and for us and for other health plans, what we have to look for, what are we willing to do in order to provide an enhanced benefit that hopefully we get our money back, we get our Medicaid dollars back by having increased healthy population? We also have, in Ohio, Kentucky, and Indiana, a lot of rural areas. There's no access to transportation. We find when you go across county lines there's this county limitation that often impacts our regional transit authorities. It's a problem. When you serve Statewide, which is where most States are going with their Medicaid programs–they're looking for Statewide providers–we're not in the transportation business, nor do we have the ability. In Ohio we have 88 counties to go out and negotiate and work with 88 different transit authorities.

We need more of a central voice and a collaboration on that. We went out in 2003 when we knew that our benefits were going to be cut and we wanted to say, "Who's using it? What is the voice of the Medicaid consumer? Is it a benefit that they truly need from us or are there other resources out there that can provide this benefit? Is it really linking them to these essential health services that we believe is the purpose for the enhanced benefit and why we're doing it?" So I just brought a couple of high level summaries so that you could get a perspective–their perspective of who they are.

As I said earlier, we're required to do if they're 30 miles or more away and it's medically necessary. We have under 30 miles, 30 one way or 15 round trip. It sounds generous, but in many of our personas that I talk through, it's not. Right now we're currently using three transportation vendors. I think that's pretty common in the Medicaid community. Like I said, we're not in the transportation business. And the vendors can choose. Do they use taxi, do they have their own drivers? Do they do a bus pass? Do they do a mileage reimbursement? Lots of challenges with both those options. In terms of the bus pass, we've got a required time that the consumer can get access to the bus pass. A lot of our consumers are our transient population. We don't always get the best addresses and locations from the State when we receive our members. Again, same with the mileage reimbursement, how do we get that to the member at the time they need the service in order to make sure that it's convenient, safe, and accessible? So lots of challenges from our perspective.

We looked at who's really using the benefit, and what we found is about six percent of our members use the enhanced benefit, so the over and above access to the transportation benefit. I recently looked out nationally and found that it's somewhere generally around seven to eight percent. 70% had less than six trips, so they were using them annually about six times a year, and only about 3.4% had greater than 30 trips. The region that had the largest usage of the transportation service was the region that had the largest members of aged, blind, and disabled consumers. They–8.25% used the benefit. And right now the locations that are allowed for the use of the benefit are your PCP or your primary care physician, a health center, to get your Medicaid program redetermination done at the State, pharmacy, and specialists.

So no ability to really, at this point, impact any of those social determinants. Some other findings is the members in the lower personas account for about a third of all the transportation users. We thought that's a little unusual because we wouldn't think that they would necessarily need access. But what we found is that the average age of the consumers in that population using it was nine. The middle personas that we focus a lot of attention on used the second highest level, and one of the areas with the strongest use were people who had uncoordinated care. And then the members in the higher personas, which is what you would have expected, are the ones who represent the highest percentage of users with 11+ trips. We wanted to dig in a little bit more to see who would be impacted if the Medicaid benefit changed.

When we looked at that first persona, what you generally consider the more healthy in the population, the average age was nine and a third of them were using it for primary care visits. In the middle persona, the individuals who had uncoordinated care, so they didn't necessarily have a PCP, they would just go to the closest provider, there was no one helping them navigate the system. And then in the third persona, which is where we find the individuals who have complex care management, they have care managers assigned by the health plan. That makes a big difference because care managers can arrange transportation. We also found that those who use the transportation benefit the most had the most grievances, so the people who were familiar and who knew where they had to go and when they needed to be there had the most grievances among our transportation providers.

So what were they using it for? What were some of the reasons that they went? In terms of physical health–asthma, obesity, cholesterol–those are all diseases that, if you have access to routine healthcare services, you can make a difference and you can improve their health. The same with behavioral health. We–in Ohio we have Medicaid expansion, and we have found that over 60% of our expansion population suffers from one or more behavioral health diagnoses. So the best way to manage our population is to make sure that they have access to their behavioral health provider and to receive their medications on a regular basis. With the children, the well checks, office visits, immunizations. How important are those? And if you think about it, Medicaid providers, we are incentivized to have healthy HEDIS outcomes, which Tyler mentioned on your HEDIS results. As a health plan, we're incentivized if we can show that a larger percentage of our population has their well child checks and they're up to date with their immunizations.

From a plan perspective, this is telling the story as to the importance of transportation and linking it to the Medicaid program. The same with our adults and our seniors focusing on their office visits and getting their testing done for chronic diseases. Here's an example. How do they use the benefit? This is one of our members whose benefit was used up and used up rather quickly, but I would argue to say that it's a prime example of why this gentleman should've had enhanced benefits. Behavioral health diagnosis; extreme complex. He used transportation for three services in a two-month period. All of the visits along the way were to his community. First he was in the hospital, which is where we found him and put him into case management. Then he went on a routine basis to see his community mental health center where he was receiving his behavioral health assistance and to the pharmacy. When he no longer went, he ended up in the ER. So enhanced cost as a direct result of not having access. These are the provider types that I walk through for the most part. They're seeing their physician for the routines and they're getting specialists, which would include our substance abuse and behavioral health clients.
From our members' point of view, we asked them: what's the top three opportunities for improvement? Their biggest complaint: not enough access to transportation, confusing, I don't know what my options are, I don't know how to get there, I don't

know how to use the bus system. In terms of our transportation, their biggest concerns were you're not on time, the drivers are often–don't know where they're going, I don't feel safe, and the wait time. I thought this was amazing: 87% would like to have transportation not just to the doctor and their prescriptions, but they need access to a food pantry and they need community organizations, and they specifically talked about the grocery store where they can get healthy food versus what they have in their current urban communities. They're willing to wait 30 minutes to an hour for that transportation, but they would also like some self-help. They'd like a mobile app, online services that they can go in and pick their own choice of transportation. Majority very interested in a provision for gas, because many use friends and neighbors for their transportation alternative, and they're very interested in public transportation. Help navigating the public transit world.

I just picked three examples of our members to give you a feel for how I believe and we advocate that enhancing a transportation benefit leads to less cost and a healthier population. Shontay has two children, Milly Hoon and Joseph. They're both CareSource members. Shontay uses the transportation benefit to insure her children get to their primary care appointments on time. She uses us as a backup plan and a support system because she has no other family members living by her in the community in which she lives. She focuses on her own financial efforts. She's trying to start a typing business. When we looked at her records to see the direct correlation with the transportation benefit, we find her children are up to date with their well checks and immunizations, and they have not accessed an emergency room in over a year.

Henry is another of our members. He suffers from bipolar, social anxiety, and epilepsy. He's dependent on several medications to manage both his mental and his physical health. In September he scheduled a ride to take him to an appointment with his psychiatrist. The appointment was at four. He was told he'd be picked up at two, he was never picked up, missed his appointment. As a result, he also didn't get his medications refilled because he used the transportation benefit to stop on his way to and from his doctor's appointments. When he discontinued suddenly, the medications caused withdrawal symptoms, ultimately led to seizures, ultimately led to a hospitalization stay. Direct correlation, access to transportation and healthcare costs.

And then finally, James. James receives dialysis three times a week. We were informed, our care management team, that he'd been missing his appointments. Unfortunately, what we do find is many of our members do not contact us when they have transportation problems. So by the time we find out when they've missed that appointment or they've shown up at the ER, it's too late to intervene and make a difference. The reason he'd been missing them is that his transportation either came late or not at all, and as a result his treatment was haphazard and resulted in more costs. In this instance, we were able, because we were contacted by the dialysis center, to intervene and to make sure that James has steady, reliable transportation to and from the dialysis center.

I just want to conclude by saying what's the ideal state from a Medicare managed care organization's point of view? Remember, we're not in the transportation business, but as you can see, we see the impact on our members, we see the impact on our community, and we believe it leads to dramatically lower costs. Hard to prove, though.

We're often challenged by our government partners to prove where we're saving money, and a lot of is avoiding more costly care, which is really hard to prove with data because you're trying to show that we avoided an ER admission or avoided someone moving to a more difficult disease state to treat. If I could pick two or three things, we think transportation as a benefit needs to be better integrated into the Medicaid programs in the States and into the programs such as the duals to make sure that it's not seen as an enhancement, it is seen as part and parcel to the healthcare benefit.

We also think it should be expanded to include addressing some of the social determinants of health. If we can get someone to a job, if we can get someone to a healthy grocery store to control their diabetes, then that should be something that's considered an essential part of the benefits. It also has to be customer-focused. We deal with members who are disabled, who may or may not have access to the internet, so it's very difficult to just put them on their own in terms of, "There's a bus in your town. Go find out what bus will take you from here to there, and by the way, when it's going to be there to pick you back up and take you home." We need to be able to have a system that's easily accessible and that's member-directed.

As you saw from our survey, many of our members are willing to pay for the transportation. What they're concerned about is the reliability, the safety, and the complexity of navigating it. We're also looking at a "one card does it all." As I mentioned earlier, we're incentivized by individuals having healthy health outcomes. So we want to be able to, on their membership card, download access to a bus token, download a card that can be used with a cab service or Uber or whatever other type of transportation the member has, so that one card does it all for the members. Our members have extremely complex lives and they're navigating many, many complex challenges, so the easier we can give them choices and outline how they can be rewarded in order to be healthy, the better it will be. Finally, our ultimate goal is to have a healthier population in all our States, and to be able to show and demonstrate the lower costs so that we can continue to expand the Medicaid program and the services that it provides.