IBM Watson Health

Are Managed Long-Term Services and Supports Expanding Access to Home and Community-Based Services?

Angie Amos & **Kristen Pavle,** IBM Watson Health
Devona Pickle, Florida Agency for Health Care Administration
Mike Randol, Iowa Medicaid Enterprise
Joe Bongiovanni, New Jersey Department of Human Services
Patti Killingsworth, Tennessee Bureau of TennCare

Home and Community-Based Services Conference
Tuesday August 28th, 2018

Agenda

I. Introductions (5)
II. 1115 Demonstration Evaluations: Rapid Cycle Reports (10)
III. Overview of Featured States' Managed Long-Term Services and Supports Programs (30)
   – Florida
   – Iowa
   – New Jersey
   – Tennessee
IV. Moderated Panelist Discussion (20)
V. Audience Question and Answer + Discussion with Panelists (10)

Introductions

State	Panelist
Florida	**Devona, D.D., Pickle,** AHC Administrator for Managed Care Policy and Contract Development, Florida Agency for Health Care Administration
Iowa	**Mike Randol**, Medicaid Director, Iowa Medicaid Enterprise
New Jersey	**Joe Bongiovanni,** Director**,** MLTSS and Contract Logistics, New Jersey Department of Human Services
Tennessee	**Patti Killingsworth,** Assistant Commissioner, Chief of Long Term Services and Supports, Bureau of TennCare, Division of Long Term Services and Supports

IBM Moderators

Angie Amos and Kristen Pavle, Senior Research Leaders, Government Health and Human Services, IBM Watson Health

1115 Demonstration Evaluations: Rapid Cycle Reports

National Evaluation of Medicaid 1115 Demonstrations

- The Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research to conduct an independent evaluation of the implementation and outcomes of section 1115 Medicaid demonstrations*
  - One of the four categories of demonstrations featured in the evaluation is managed long-term services and supports (MLTSS)
  - IBM Watson Health produces one of the research products: a series of rapid-cycle reports, or RCRs, that feature key aspects of MLTSS

**contract number HHSM-500-2010-0026I*

MLTSS Rapid Cycle Reports

- A qualitative approach to evaluating MLTSS programs through both 1115 and 1915 Medicaid authorities
  - Offers a deep-dive into states MLTSS programs through key-informant interviews and analysis of state MLTSS documentation
- RCR topics selected based on identified priorities for MLTSS programs
- 4 RCRs completed to date
  - Who Enrolls in Medicaid Managed Care Programs that Cover Long-Term Services and Supports (LTSS)?
  - Do Managed Care Programs Covering LTSS Reduce Waiting Lists for Home and Community-Based Services (HCBS)?*
  - How MLTSS Programs Interact With Federal LTSS-Related Initiatives
  - The Impact of MLTSS on Access to LTSS*

**Featured in our presentation today*

Rapid Cycle Reports on Access

"Do Managed Care Programs Covering LTSS Reduce Waiting Lists for HCBS?"

- 8 states
  - Delaware
  - Florida*
  - Michigan
  - New Jersey*
  - New Mexico
  - Tennessee*
  - Texas
  - Wisconsin

MEDICAID 1115 DEMONSTRATIONS

July 2017

Do Managed Care Programs Covering Long-Term Services and Supports Reduce Waiting Lists for Home and Community-Based Services?

Paul Saucier, Jessica Kasten, and Angie Amos

Introduction

States are implementing programs for Medicaid managed long-term services and supports (MLTSS) in part to reduce avoidable use of institutional services and expand access to home and community-based services (HCBS). One potential measure of this utilization shift is reduction or elimination of HCBS waiting lists. In theory, states can use savings from lower utilization of institutional services to expand the number of available HCBS slots and reduce the number of people waiting for services.

This brief examines changes in the number of people on HCBS waiver waiting lists in a sample of eight MLTSS programs (see Table 1) and identifies MLTSS features that may be associated with the changes as well as other factors that are not directly associated with managed care. The brief also discusses challenges with using waiting lists as a measure of HCBS access and identifies other HCBS access measures used by states.

Key findings. Among seven states that had waiting lists for HCBS waivers before the start of the MLTSS program, two states eliminated the wait for services and four states decreased the number of people on their waiting lists after the MLTSS programs began. The rate of decrease ranged from 12 percent in New Mexico to 92 percent in Wisconsin. One state had virtually no change in its waiting list. The eighth state in the study (New Jersey) did not have an HCBS waiting list before or after MLTSS program implementation. States attributed decreases in their HCBS waiting lists to multiple factors, including but not limited to the MLTSS program. Five of the eight states cited expanded funding as an additional factor in reducing their waiting lists.

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid, which is administered by states, is jointly funded by state and federal governments. Within a framework established by federal statutes, regulations, and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches for administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

For the past two decades, states have increasingly turned to private managed care plans to deliver long-term services and supports (LTSS) to Medicaid beneficiaries with disabilities who need assistance with activities of daily living. Section 1115 is one of several federal authorities that states can use to operate managed long-term services and supports (MLTSS) programs. In contrast to fee-for-service, which pays providers for each service they deliver, states that operate MLTSS programs pay managed care plans a fixed per member per month (PMPM) amount to provide all covered services for enrollees. The capitated PMPM payment arrangement—combined with contract requirements to protect enrollees—can create an incentive for the plans to improve care coordination, reduce unnecessary services, and increase the availability of less costly home- and community-based services as an alternative to institutional care.

**Participating on today's panel*

Rapid Cycle Reports on Access

"The Impact of MLTSS on Access to LTSS"

October 2017

MEDICAID 1115 DEMONSTRATIONS

The Impact of Managed Long-Term Services and Supports (MLTSS) Policies on Access to LTSS

Kristen Pavle, Paul Saucier, Angie Amos, and Jessica Kasten

Introduction

Managed long-term services and supports (MLTSS) programs have grown significantly in recent years. The total national enrollment in MLTSS programs increased from an estimated 600,000 in 2012 to nearly 1.7 million in 2017 (Lewis et al. forthcoming). In response to rapidly transforming LTSS systems around the country, the Centers for Medicare & Medicaid Services (CMS) issued guidance on MLTSS in 2013 (CMS 2013), which was integrated into the May 2016 federal Medicaid and CHIP Managed Care Final Rule (hereafter the Final Managed Care Rule) (81 Fed. Reg. 27497 (May 6, 2016)).

The 2013 guidance and 2016 Final Managed Care Rule modernized the framework for federal oversight of MLTSS access, with requirements that address LTSS network adequacy, transitions from fee-for-service LTSS to MLTSS, and inclusion of LTSS in quality assurance and performance improvement programs, among others. However, standardized national measures for LTSS access remain a work in progress. A Medicaid access measurement plan prepared for CMS in 2016 did not include LTSS measures, noting the nascent state of measure development in this area (Kenney et al. 2016). Additionally, the Government Accountability Office recently noted the lack of standardized reporting in this area (GAO 2017).

This brief identifies and compares MLTSS policies that four states (Delaware, Iowa, New Jersey and Tennessee) consider important to ensuring LTSS access: network adequacy standards, transition of care policies, provider reimbursement policies, level of care criteria, participant-directed services policies, and care coordination models. Understanding which MLTSS policies affect access and how they vary across states and over time enables evaluators to control for variations in those policies in their analyses.

MLTSS Policies That Influence Access to LTSS

The states interviewed for this study (Delaware, Iowa, New Jersey and Tennessee) agreed that maintaining access to LTSS is critical to the success of MLTSS, and that certain policies are central to achieving that objective. Four policy areas—network adequacy standards, transition of care, provider reimbursement, and level of care criteria—were cited as key in all four states. Two states noted participant-directed services policy, and one mentioned the care coordination model, as well.

THE MEDICAID CONTEXT

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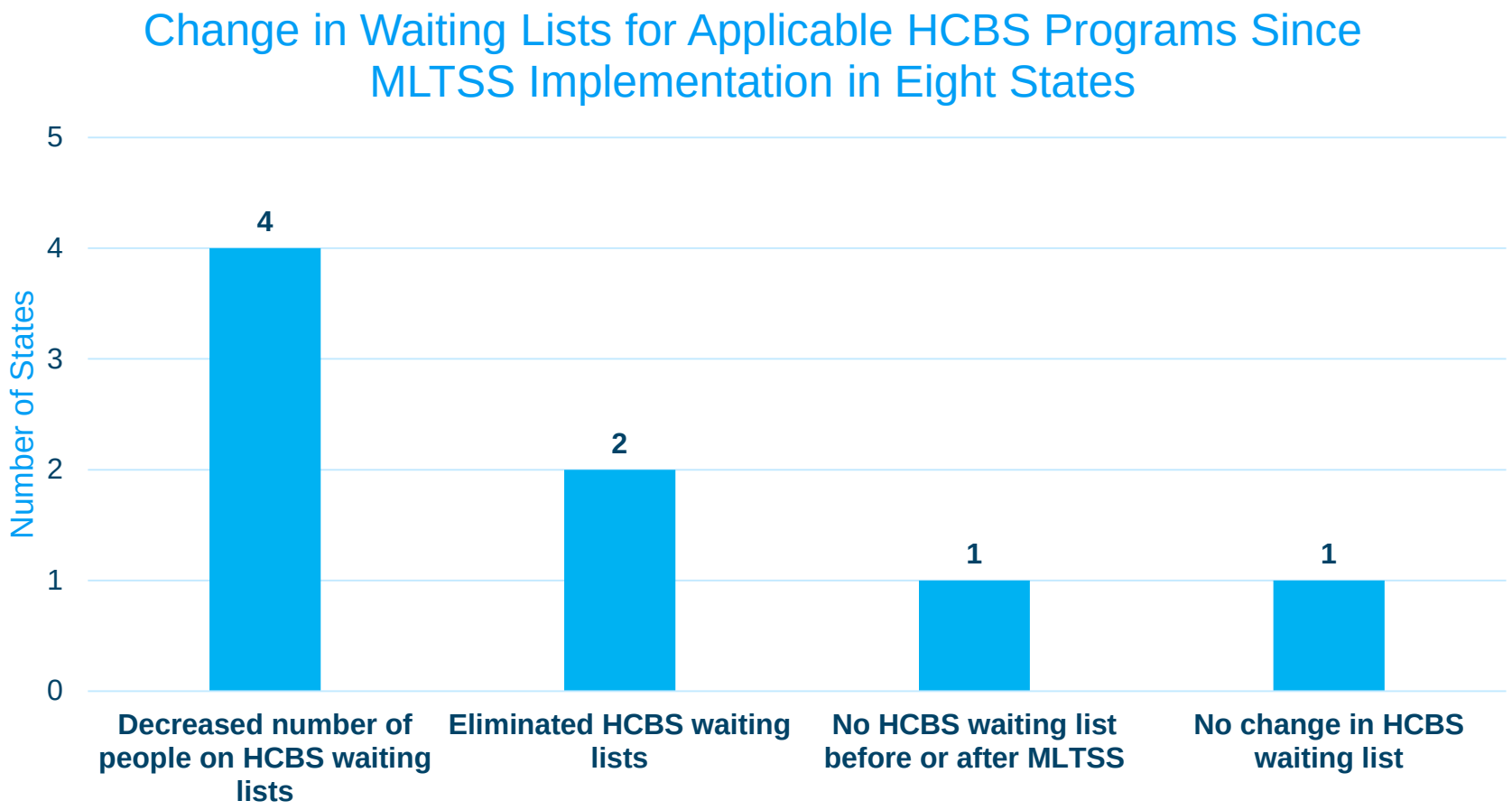
For the past two decades, states have increasingly turned to private managed care plans to deliver long-term services and supports (LTSS) to Medicaid beneficiaries with disabilities. Section 1115 is one of several federal authorities that states can use to operate managed long-term services and supports (MLTSS) programs. In contrast to fee-for-service, which pays providers for each service they deliver, states that operate MLTSS programs pay managed care plans a fixed per-member-per-month (PMPM) amount to provide all covered services for enrollees. The capitated PMPM payment arrangement – combined with contract requirements to protect enrollees—can create an incentive for the plans to improve care coordination, reduce unnecessary services, and increase the availability home and community-based alternatives to institutional care.

- 4 featured states:
  - Delaware
  - Iowa*
  - New Jersey*
  - Tennessee*
- 4 policy areas featured:
  - Network adequacy standards
  - Transition of care
  - Provider reimbursement
  - Level of care criteria

**Participating on today's panel*

Most States Eliminated or Reduced Waiting Lists for HCBS



HCBS waiting list reductions have been observed in MLTSS programs but other access measures are preferred

- Waiting list data are generally not reliable
  - Not comparable across states and sometimes not comparable within states
- States believe MLTSS can decrease waiting lists but cite additional factors that affect access to HCBS, such as:
  - Expanded state funding and/or new federal opportunities (e.g., MFP)
  - State policy changes making HCBS an entitlement (e.g., personal care services)
  - Improved front door via aging and disability resource center (ADRC) development

Access-related MLTSS policies have been effective during FFS-to-managed care transitions but longer-term impacts are unknown

- Continuity of Care policies have preserved LTSS access during the move from FFS to managed care
  - Transitional periods ranged from 30-180 days in our 4 study states
- Any Willing Provider policies continue to protect access to nursing facilities and HCBS
  - More common for nursing facilities
- State-established minimum managed care rates tied to FFS implemented for both nursing facilities and HCBS
  - More common for nursing facilities

Stakeholders support access protections, but measuring access remains a challenge

- Providers are concerned that access will be impacted if transitional policies expire
- States support transitional policies but believe that plans must have flexibility to manage network in order to improve quality in the longer-term
- States are moving toward “achieved access” standards
  - For example, the time it takes from authorization to delivery of services.

Overview of Featured States' MLTSS Programs

Florida:
MLTSS and Access to LTSS

Devona, D.D., Pickle, AHC Administrator for Managed Care Policy and Contract Development, Florida Agency for Health Care Administration

Florida Medicaid Managed Care: Long Term Care Program– A Snapshot

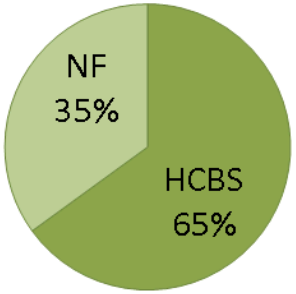
Program Enrollment	• Recipients are mandatory for enrollment if they are:
	  • 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
	  • Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require:
	  • Nursing facility care as defined in s. 409.985(3); or
	  • Hospital level of care, for individuals diagnosed with cystic fibrosis.
	• 100,000 recipients currently enrolled in LTC health plans
	• New Population have been added to LTSS in 2 phases: 2013 and 2018

Mechanisms for Expanding Access	• Blended capitation rates and other rate incentives for transition to the community • Community High Risk Pool (CHRP) to avoid plan disincentives for transition of high cost enrollees • Expanded benefits provided by plans at no additional cost to the state • Consumer Direction

Florida's LTC Rate Methodology

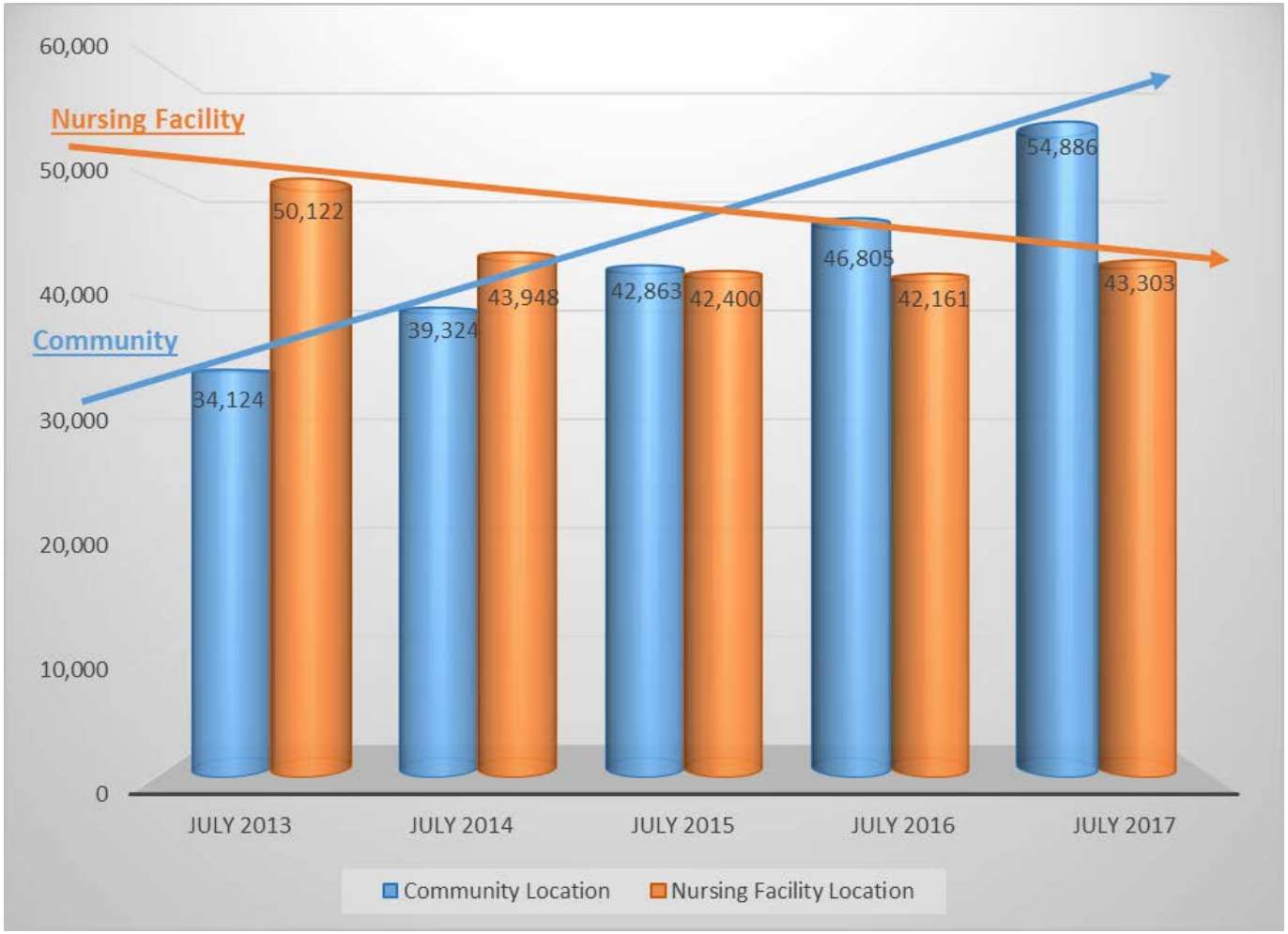
- Methodology for blending Nursing Facility vs. HCBS rate also incentivizes transition
- The law requires that base rates be adjusted to provide an incentive for plans to transition enrollees from nursing facilities (NF) to the community (HCBS).

Required Transition Incentive Until 35% NF



- An enrollee who starts the year in a nursing facility is treated as NF for rate blending for the entire year, even if they are transitioned to the community. A similar situation applies for enrollees starting the year in the community.
- Plans "win" financially if they beat the target transition percentage, "lose" if they do not meet the target.

LTC Transition Incentive Success



Better Health Care for All Floridians
AHCA.MyFlorida.com

Avoid Disincentives to Transition: Florida LTC Community High Risk Pool (CHRP)

- Community High Risk Pool Put in Place to Assist Plans with High Cost Members in the Community
  - To re-allocate funds among the LTC plans to account for HCBS high cost recipients whose average monthly HCBS claims exceed a threshold of $7,500 per month during each quarterly disbursement period.
  - Capitation dollars are withheld from the HCBS rate on a per member per month basis.
  - Those dollars are re-distributed to plans based on the risk of the plan enrollment as determined by their claims exceeding a dollar threshold.
  - Revenue Neutral to State – The dollars distributed do not exceed the dollars withheld.

Expanded Benefits: Additional Services Provided at No Additional Cost to the State

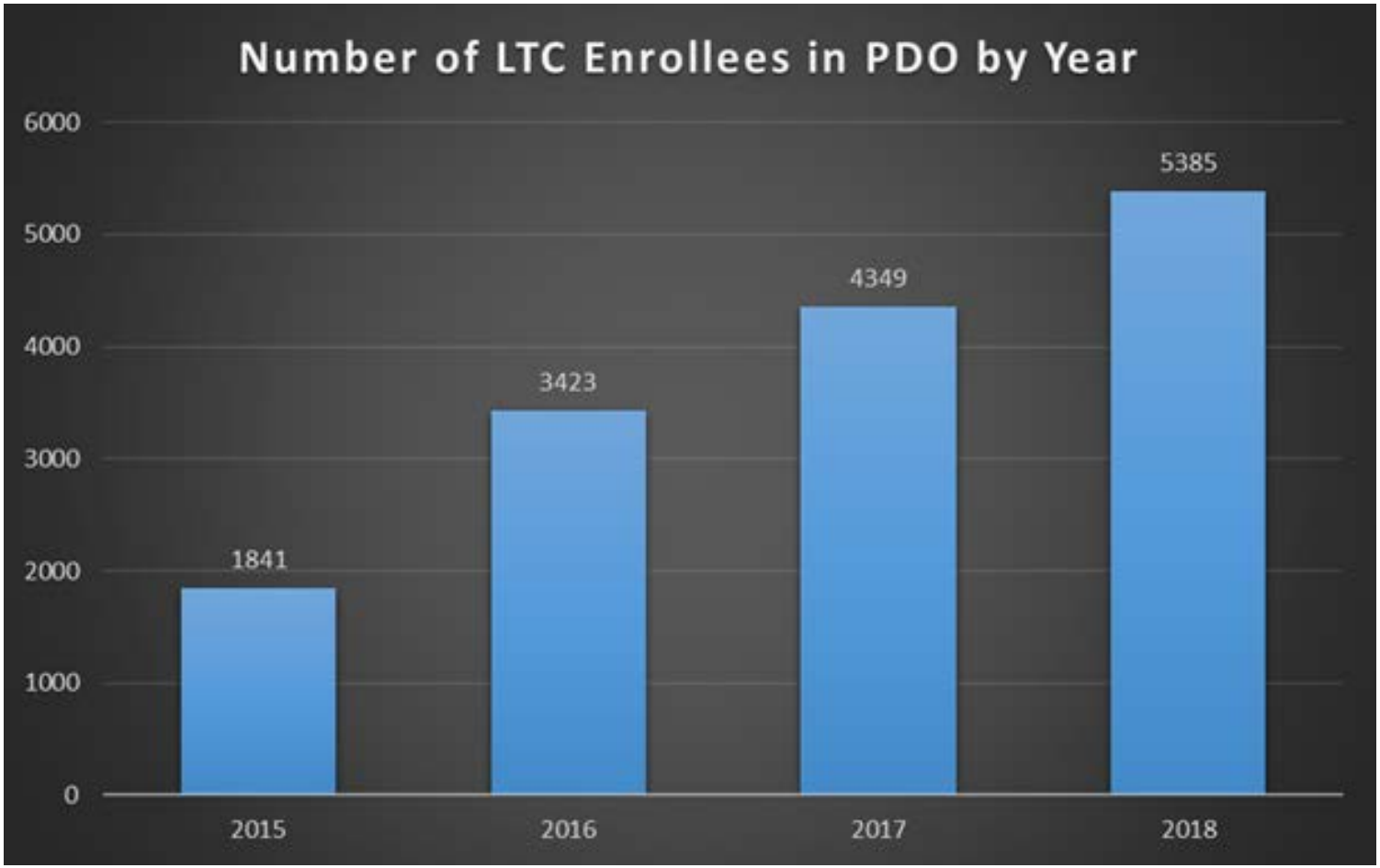
- Under the current contracts, Florida's LTC plans offer specific Expanded Benefits to the LTC enrollees. These are benefits provided above the "normal" Medicaid HCBS benefit at no cost to the state.

- Under the NEW contracts, all plans that provide LTC services with ALSO provide MMA services to their enrollees. All enrollees will be offered a rich Expanded benefits package including more than 55 benefits.

Participant Directed Option (PDO)

- A services delivery model in which participants hire, train, supervise, and dismiss their direct service worker (s). Available to:
  - All LTC enrollees who live in their own home or family home, AND
  - Who have at least on of the following services on their care plan
    - Adult Companion Care
    - Attendant Care
    - Homemaker
    - Intermittent and Skilled Nursing
    - Personal Care

PDO Enrollment Success



Iowa Health Link

Director Mike Randol

mrandol@dhs.state.ia.us

MLTSS Population in Iowa

- 37,412 – as of March 2018
  - About 60 percent are receiving Community Based Services
  - 40 percent are receiving Facility Based Services – ICF/ID, Nursing Facility, PMIC
- Two MCOs; Third to join July 2019
- Iowa currently has seven HCBS Waivers

Network Adequacy

- Iowa has a large rural population which has always been a challenge in both FFS and Managed Care
- Access standard: 1 primary care provider within 30 miles
- There are a limited number of specialty providers across the state
  - 1 provider within 60-90 miles

Care Coordination Model

- When managed care started in Iowa in 2016, MLTSS members were free to choose the care coordination model of their choice
- Two MCOs provided an in-house model; the third allowed members to keep their existing care coordinators in community agencies
- Majority of members chose the community based approach

Care Coordination Continued

- MCO that had community based approach ended up leaving Iowa
- Members were then transitioned to the other two MCOs
- Lesson learned:
  - Maintaining access to specific care coordinators is important to HCBS members

Access to HCBS in MLTSS
NASUAD HCBS Conference
August 2018

Joseph Bongiovanni
NJ Department of Human Services
Division of Medical Assistance and Health Services

NJ Comprehensive Medicaid Waiver (CMW)

- NJ CMW is an 1115 demonstration that was renewed effective 8/1/2017-6/30/2022 to continue:
  - Implementing statewide health reform through our current managed care programs to include MLTSS and expand **home and community based services (HCBS)**

- **Managed Long Term Services and Supports (MLTSS)** is a component of the NJ Comprehensive Medicaid Waiver

What is MLTSS?

- **MLTSS Philosophy:**
  - **To Maintain Individuals in the Community Through:**
    - Improved care coordination and better health outcomes (breaking down silos: physical health, mental health/substance abuse, long-term care)
    - Cost reduction
    - Consumer choice and home-based care

What is MLTSS? continued

- **NJ FamilyCare Managed Long Term Services and Supports (MLTSS) include the following services:**
  - Personal Care; Respite; Personal Emergency Response System (PERS); Home and Vehicle Modifications; Home Delivered Meals; Assisted Living; Behavioral Health Services; Community Residential Services; and Nursing Home Care

- **Individuals are able to access:**
  - Health care providers and services within managed care networks to meet identified needs; and
  - A care manager to help coordinate medical, long term services and supports, behavioral health services and NJ FamilyCare state plan services, such as medical day care and personal care assistance, through an individualized plan of care.

Eligibility for MLTSS

An individual is eligible for the MLTSS program when he or she meets nursing home level of care (LOC) determined by the pre-admission screening (PAS) completed by the MCO or the Office of Community Choice Options (OCCO)

- **Clinical** Eligibility
  - A person meets the qualifications for nursing home LOC, when s/he requires limited assistance with a minimum of three (3) activities of daily living (ADLs) such as bathing, toileting and mobility; or the consumer has cognitive deficits and ADL needs of supervision in greater than 3 ADL areas

- **Categorical** Eligibility
  - Aged – 65 years old or older, or
  - Blind ***or*** Disabled – Under 65 years of age and determined blind or disabled by the Social Security Administration or the State of New Jersey

Eligibility for MLTSS Continued

- **Financial** Eligibility
  - Institutional Medicaid
    - Apply at the CWA
      - **Income** for one person can be equal to or less than $2,250 per month (2018)
      - Income for a couple can be equal to or less than $3,375 per month (2018)
      - All income is based on the gross amount
      - **Resources** must be at or below $2,000 for an individual and $3,000 for a couple

Care Management

- MLTSS provides enrollees a care manager to help coordinate medical, long term services and supports, behavioral health services and NJ FamilyCare (Medicaid) State Plan services, through an individualized plan of care

- MCOs care manage NJ FamilyCare state plan benefits, MLTSS and behavioral health
  - Primary Care
  - Acute Care
  - LTSS
  - Substance Abuse Services
  - Mental Health Services

NJ Self-Direction: Personal Preference Program

- Medicaid State Plan
  - Budget Authority: Cash value of assessed hours of PCA service
  - Employer Authority: Member or authorized representative is employer of record
  - Currently evaluating how to leverage managed care

Providers and Network Adequacy

TRADITIONAL PROVIDERS

- Home health agencies
- Home care agencies
- Assisted living facilities
- Community residential facilities
- Therapists

NON-TRADITIONAL PROVIDERS

- Home modification contractors
- Furniture stores
- Neighbors/relatives (PCA)
- Cleaning service (chore care)

Providers and Network Adequacy Continued

- Any Willing Provider
- Any Willing and Qualified Provider

MLTSS Headlines

- July 2014 (Inception of MLTSS)
  - 29.4% of NJ FamilyCare LTC population is in Home and Community Based Services
- October 2015:
  - 36.3% of the NJ FamilyCare LTC Population is in Home and Community Based Services
- April 2018:
  - 49.4% of the NJ FamilyCare LTC Population is in Home and Community Based Services

- Number of Recipients Residing in Nursing Facilities is Down Over 1,600 Since the July 2014 Implementation of MLTSS

Expanding Access to HCBS in Tennessee

National HCBS Conference, 2018

Service Delivery System in Tennessee

- TennCare managed care demonstration began in 1994
- Operates under the authority of an 1115 demonstration
- *Entire* Medicaid population (1.4 million) in managed care since 1994 (including dual eligibles and people with disabilities)
- Three health plans (MCOs) operating statewide
- Physical/behavioral health integrated beginning in 2007
- Managed LTSS began with the Statewide ***CHOICES*** program in 2010
  - Older adults and adults with physical disabilities *only*
- 3 Section 1915(c) waivers and ICF/IID services for individuals with I/DD carved out; operated by State I/DD Department (people carved in for physical and behavioral health services)
- New Statewide MLTSS program for individuals with I/DD began July 1, 2016: ***Employment and Community First CHOICES***

TN


TennCare
CHOICES
in Long-Term Services and Supports

Program Objectives (Baseline Data Plan)

#1: Expand access to HCBS

- # receiving HCBS versus NF services
  (point in time and unduplicated across the year)

#2: Rebalance LTSS spending

- Total HCBS versus NF expenditures

#3: Provide cost-effective HCBS as an alternative to institutional care

- Average per person NF versus HCBS expenditures

#4: Delay or prevent institutional placement

- Average length of stay in HCBS
- Percent of new LTSS members admitted to NFs

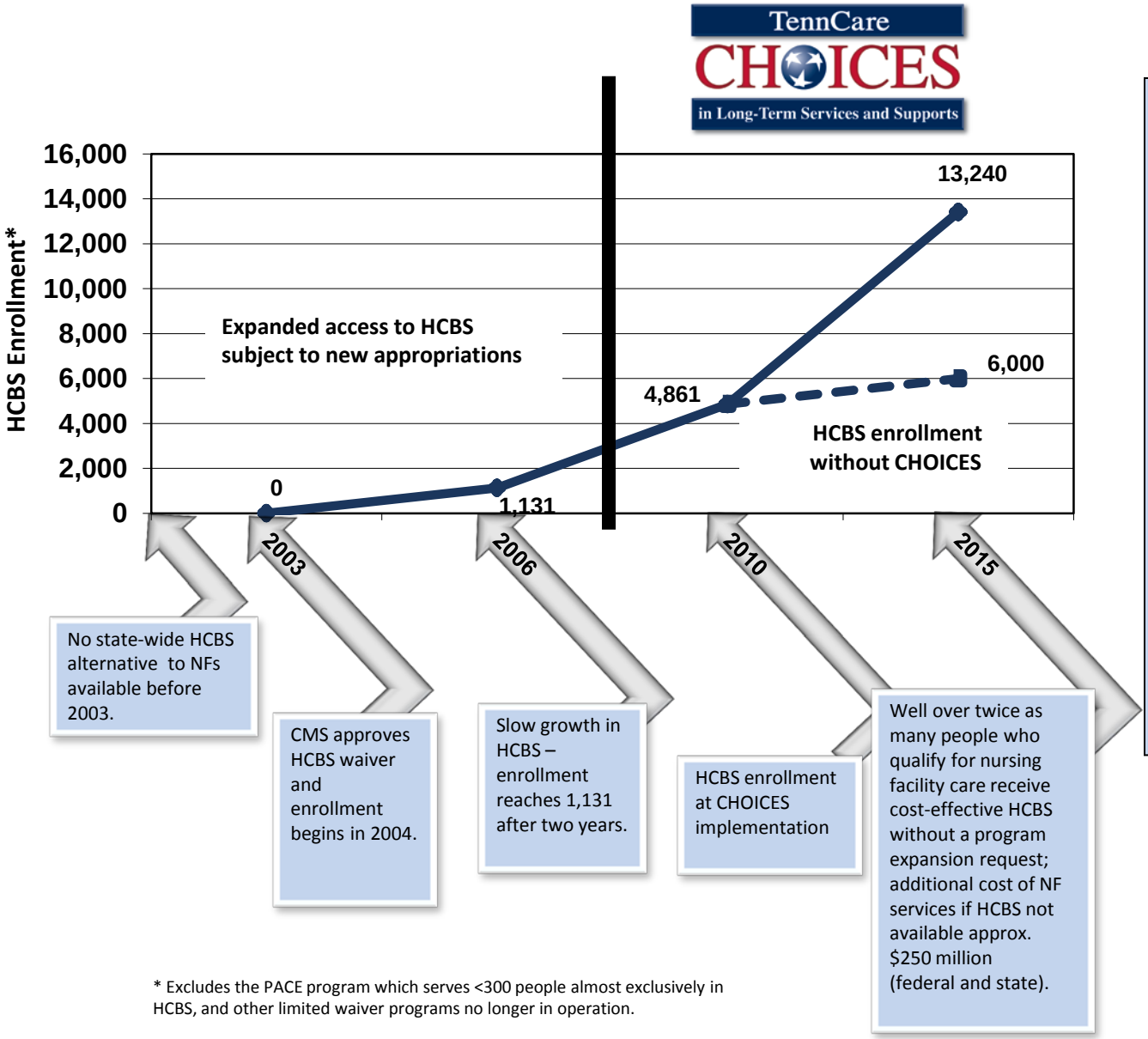
#5: Facilitate transition from NF to HCBS

- Average length of stay in NF
- # NF-to-community transitions

Strategic Program Design Elements

- Nursing facility services **and** HCBS carved in
- MCOs at full risk for all services, including NF (not time-limited)
- Blended capitation rate for NF eligible population (even if receiving HCBS)
- Higher level of care standards for NF services, access to HCBS for "at-risk"
- Contractual requirements regarding nursing facility diversion and transition processes and timelines
- MFP Rebalancing Demonstration and incentive payment structure
  - Every transition under MFP
  - Upon completion of the 365 day MFP participation period
  - MFP transition targets
  - HCBS vs. institutional expenditures
  - HCBS vs. institutional participants
  - Development of community based residential alternatives
  - Participation in consumer direction

Access to HCBS before and after…



- **Global budget approach:**
  - Limited LTSS funding spent based on needs and preferences of those who need care
  - More cost-effective HCBS serves more people with existing LTSS funds
  - Critical as population ages and demand for LTSS increases

HCBS waiting list eliminated in CHOICES

* Excludes the PACE program which serves <300 people almost exclusively in HCBS, and other limited waiver programs no longer in operation.

CHOICES Outcomes

- # of persons receiving HCBS in CHOICES increased by nearly 170% in first 5 years (from 4,861 to 13,240, as of 6/30/15); HCBS enrollment 12,385 as of 6/30/18
- # of persons receiving NF services in CHOICES has declined by more than 6,600 people (from 23,076 to 16,439, as of 6/30/18)
- % of people coming into LTSS in a NF declined from 81.34% in the year preceding CHOICES implementation to less than 50% during FYs 2013, 2014, and 2015, with more than 50% of people choosing HCBS upon enrollment in CHOICES for 3 consecutive years
- More than 4,000 individuals transitioned from NFs to HCBS as of 6/30/17, an average of almost 600 per year, compared to 129 people in the baseline year immediately preceding CHOICES

Employment and Community First CHOICES

HCBS enrollment for individuals with I/DD

- **2,062** – Total new enrollment into 1915(c) waivers prior to implementation of MLTSS - FY 2011-2016 (6 years)
- **2,539** – Total enrollment in Employment and Community First CHOICES (MLTSS) as of July 2018

- **We have enrolled more people with I/DD into HCBS in the last *24 months* than in the previous *6 years***

- **For the first time in the State's history, people with developmental disabilities *other than an intellectual disability* have access to HCBS**

Employment-Related Enrollment Categories

Priority Category	Target Population
A	Individuals who have a job but need help keeping their job.
B	Young adults (18+), preparing to transition from education or training to the workforce, who have a job offer but need supports to accept the offer.
C	Individuals who have lost their job and need help finding and keeping a new one.
D	Young adults (18-22) preparing to transition from education or training to the workforce, who need help finding and keeping a job.
E	Individuals who do not have a job, but want to work and need help finding and keeping a job.
F	Youth (14-22) in school and living at home who need help preparing to transition to the workforce.
G	Individuals (14-62) who do not have a job but are open to the possibility of working and agree to participate in career exploration services.

* Reserve capacity based on caregiver age/health, emergent circumstances, etc.

Flexible employment-focused benefit design

- **Tiered benefit packages** target resources more efficiently; serve more people, reduce waiting list over time
- Array of **14 different Employment Services** create a pathway to employment even for people with significant disabilities
- ***Employment Informed Choice*** process ensures that employment is the *first* option considered for every person of working age ***before*** non-employment day services are available
- **Comprehensive and flexible wrap around and supportive services**, including self-advocacy and family supports, and self-directed options to support active community participation and independence
- **Value-based payment** aligns incentives with employment goals
  - **Outcome-based reimbursement** for pre-employment services
  - **Tiered outcome-based reimbursement** for Job Development and Self-Employment Start-Up based on person's "acuity" level and **paid in phases to support retention**
  - **Tiered reimbursement for Job Coaching** based on person's "acuity" level, length of time employed, and amount of support as a % of hours worked

Payment is higher per hour if fading achieved is greater.

Facilitated Panelist Discussion

Question #1

If you could change anything in your MLTSS program to improve access to HCBS, what would it be? Why?

Question #2

Were there any unexpected outcomes related to access to HCBS that resulted from the implementation of your MLTSS program(s)?

Question #3

What concerns did you have or do you currently have about MLTSS potentially limiting access to HCBS?

- How did you overcome these challenges?

Question #4

What are the next steps in your state for addressing key HCBS access policies in your MLTSS program(s)?

Questions from the audience

- What additional questions do you have for our panelists?

Thank you for your time today!

- A big thank you to our state panelists—thank you for sharing your experience and expertise
  - For more information on the 1115 Demonstrations Evaluation and to find the MLTSS related reports, please visit: https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/index.html

- Feel free to reach out to Angie Amos or Kristen Pavle for more information on our MLTSS work
  - aamos@us.ibm.com or kpavle@us.ibm.com