

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, September 23, 2010
12:38 p.m.

COMMISSIONERS PRESENT:
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JUDITH MOORE
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LU ZAWISTOWICH, ScD,
Executive Director

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CHAIR ROWLAND: Welcome. It is my pleasure as the Chair of MACPAC to call this meeting to order and to begin public deliberations of the Medicaid and CHIP Payment and Access Commission, which we have named MACPAC. We look forward to being able to fulfill the many responsibilities that the Congress has given to us in terms of advising on the Medicaid and CHIP programs, how to make these programs work more effectively and efficiently, and how to provide the services to the beneficiaries that depend on them. And we really welcome those of you who have joined us today for our first public meeting. It's nice to see the interest. We are excited to have you with us and to be able to begin to think through the challenging issues before us.

As we begin, I wanted to briefly review what some of the responsibilities are and the history of the Medicaid and CHIP Payment and Access Commission and to remind us of its beginnings. It was established by the Children's Health Insurance Program Reauthorization Act, CHIPRA, in February of 2009, and the GAO, in responsibility for making the appointment, carried out its responsibilities and named those of us who sit here as Commissioners by December of 2009. And many of you in the public began to wonder when MACPAC was going to meet and begin its work. But, unfortunately, CHIPRA named us, CHIPRA set us up, but it didn't fund us, and so it took health reform to both give us the funding to begin our work as a Commission, and also through health reform we got a very expanded set of responsibilities that tasked us with more than just reviewing state and federal Medicaid and CHIP access and payment policies as they affected children, but expanded it to a broader range of all of the key challenges facing the Medicaid program.

We, like our companion agency that looks at Medicare, MedPAC, are also required to submit reports to Congress on March 15th and June 15th of each year. We were even required to do that before we were funded and operational.

I am pleased, though, that today we are operational. We do have a staff, and we are sitting here as a Commission with an Executive Director, Lu Zawistowich, and a key staff that's on the side of the room who will be helping us to move forward with our deliberations.

We do have a substantial number of duties that the Congress gave us in the authorizing legislation, first in CHIPRA and then expanded through the health reform legislation. One of the major topics is to review and make recommendations on the following issues: payment policies and relationship and access and quality of care for beneficiaries; eligibility policies as well as enrollment and retention processes; coverage policies; quality of care; interactions with Medicare and Medicaid, including consultation and coordination between MACPAC and MedPAC; and other access policies related to transportation and language

barriers, preventive, acute, and long-term care services and supports. In other words, a very broad set of issues related that encompass virtually all aspects of the Medicaid program as well as the CHIP program.

We are to review and submit our reports and recommendations on both national and state-specific Medicaid and CHIP data, so we add to the dimension of being responsible for making recommendations to the Congress, consultation with the states, trying to figure out how the policy recommendations that we will develop will affect not only the Federal Government and its responsibilities, but the implementation of the program in the states.

We were also charged in the legislation with creating an early-warning system to identify provider shortage areas and other factors that adversely affect access to care or the health status of the beneficiaries of Medicaid and CHIP.

We also have been asked to review and comment on secretarial reports and regulations that relate to access policies under Medicaid and CHIP, so we'll be reviewing the many regulations that will be coming out from CMS around the Medicaid and CHIP programs. And as you see from our agenda, we'll be starting tomorrow morning's session with hearing directly from Cindy Mann about some of the issues facing their implementation of health reform as well as their ongoing operational responsibilities for Medicaid and CHIP.

And then we are, by the end of the next two years, to begin to report on alternatives to current tort legislation and determine the impact on Medicaid and the CHIP programs.

So it is an overwhelming agenda. It is one that has a lot of responsibilities and one that we need to prioritize how to begin our work. We are a new Commission. We are just starting up. We have been spending much of our time trying to get our website together, trying to get organized, and these responsibilities will clearly take more than the ability to handle every issue in the next few meetings.

So one of our primary goals and the reason that we have begun our work today is to try and shape our agenda to figure out which issues we can tackle first, what responsibilities are being expected of us in the immediate future, and you will hear that discussion as we begin our deliberations today.

I think it is, however, very important that you reflect on the challenges that we have, but the qualities of the Commission members that the Congress sought to put here I think will help us to begin to address many of these responsibilities.

The legislation in CHIPRA set out the appointment by the GAO of 17 Commission members that would come from a wide variety of backgrounds to bring great expertise to the issues that we will be dealing with today. We wanted Commission members who have direct experience with enrollees

or as parents of enrollees in Medicaid and CHIP. They wanted expertise in federal safety net programs, health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement experts for health facilities, and health information technology. And as we go around and introduce you to our Commission members, you will see that they share that expertise.

In addition, pediatric physicians, dentists, and other providers of health services, representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual-eligible individuals are also to be taken into account, as well as individuals with on-the-ground experience as representatives of state agencies responsible for administering Medicaid and/or CHIP. And as we move forward in our deliberations, the members of the Commission will each vote on recommendations contained in reports to Congress, so we will be working to establish both an information and knowledge base about Medicaid and CHIP, identifying the key issues, and then moving to make recommendations about how to improve and make changes in the programs.

As we go through that, the broad consultation with states, with the federal government, and with those of you in the public representing different interests will be part of our deliberations and will help to shape the direction that we as a Commission take.

A few facts that I think we want to be sure are on the table that we begin to understand about the programs we are dealing with: Medicaid, of course, has been around for a long time but has been reshaped in many ways and will continue to be reshaped by health care reform. But today it covers nearly 60 million individuals and almost a third of all children, which helps to understand the focus that the Congress originally gave us on looking at how this program operates on behalf of children. But it also covers over 8 million low-income people with physical and mental disabilities who have special needs that this Commission will need to address and take into account. And as our mandate was broadened, we also need to look at the responsibilities that program takes for the 7 out of 10 nursing home residents who are covered by Medicaid and for the 9 million low-income Medicare beneficiaries for whom Medicaid serves as a complement, and in many cases it's a major source of assistance.

We cannot forget, as we look at the broad Medicaid program and its wide scope, that one of the mandates from Congress was also to look at the Children's Health Insurance Program, CHIP, which was created in 1997 as a companion actually to Medicaid to provide coverage to children above the Medicaid level, now covering some 7 million children, with expanded funding through 2013 from CHIPRA and then extended through the health reform legislation to be funded through 2015, with responsibilities until 2019. So these

two critical programs will form the major focus of our efforts to look at health insurance and coverage for low-income individuals in the U.S.

We will be looking at them because they are such a major part of our health care spending and our health care coverage. Today Medicaid and CHIP cover 13 percent of the American public. But as the number of uninsured are moved between Medicaid and the exchanges, that number will grow so that Medicaid will take an even greater share of coverage. And it accounts, obviously, for a substantial share of national spending, accounting for some 16 percent of overall health care spending today.

So together we are looking at a very substantial share of our health insurance coverage in America as well as our health care spending, and how to reshape that will be a critical part of the work we do.

We know that many of the challenges that we are going to be facing will relate to how to provide better payment policy and to change and improve payment policy; and not only does the Medicaid program affect 16 percent of overall health care spending for personal health care services, it is a much more substantial player in different parts of the provider community, accounting for some 17 percent of hospital care but over 41 percent of nursing home care and 8 percent of prescription drugs. Even after the Medicare program has shifted some of that responsibility with the Medicare Prescription Drug Act, Medicaid still is a major purchaser of prescription drugs.

And when we think about the program and we think about the responsibilities in the program, we have to remember that it serves very different populations with very different needs. Although the face of Medicaid has largely been that of children -- 49 percent of the enrollees in the program are children -- the expenditures on behalf of children are quite modest compared to those of the other individuals served who are elderly and disabled. So children account for nearly half of the program enrollees but only 20 percent of the spending. Their parents and other adults add about 25 percent more of the enrollees and about 12 percent of spending. Yet it is the elderly and the disabled, one-quarter of the beneficiaries, who account for 67 percent of the overall spending, and within that, 15 percent of all enrollees on Medicaid are dual eligible -- that is, have Medicaid and Medicare together, an area that the Congress has asked us to work on and to look at in conjunction with MedPAC. And the duals, who represent 15 percent of enrollees, account for 40 percent of expenditures as Medicaid helps to fill in for acute and long-term care services for those on the Medicare program.

I think it is striking when we look at the smaller number of people who are dual eligibles and the substantial level of spending to really think about what it is that we are doing on a per capita basis among Medicaid beneficiaries. And here you see that even though most of

the elderly have Medicare as a primary source of coverage, on a per capita basis more is spent on acute care services for the elderly than on overall services for children and adults. So that one of the clear issues that we've been asked to look at is how to better coordinate care, how to better improve care for the dual eligibles and those who are among the highest spenders within the Medicaid population, so that we will be clearly having to focus on looking at for that population the integration of both medical services and long-term care services and how to coordinate between Medicare and Medicaid more effectively. And we are anxious this afternoon to learn from Mark Miller, the Director of MedPAC, what some of the work underway at MedPAC is that we are charged with coordinating.

As we look through these programs, we also should be mindful of the fact that health reform is bringing substantial changes. Today the income levels and coverage for children have become quite generous across the states as the combination of Medicaid and CHIP together, but as the next slide shows, the coverage for parents lags considerably below, and this is one of the areas where the eligibility challenge that the Congress has given us is how to expand and improve eligibility through health reform, to bring in participation not only from working parents who are covered in many states at very low income levels, but also to add coverage to childless adults. So it is one of the challenges that the health reform legislation places on the MACPAC table.

But as we move forward, one of the real challenges that relates to the overall charge in our name, Access and Payment Commission, is once someone is eligible for Medicaid or for CHIP, what happens to them? What does the card for coverage convey? Where do they get their coverage? How does the delivery system work for those beneficiaries? And how can we improve the way in which care is coordinated, the quality of that care, and the arrangements for payment.

What you see from this map is that states have begun to engage in various forms of managed care, some as lightly coordinated as primary care case management, others into capitated managed care. And the whole role of managed care and of providing improved access is going to have to be one of the major challenges that this Commission meets. That's why I think we have begun our deliberations today by focusing on what is known about access and payment and some of the challenges on the ground, and we will begin to focus on shaping our agenda around these issues on trying to begin to put together some of the information that can help Congress make informed decisions about where to go forward with some of the federal payment policies, but also how to provide better information and options to our states that are trying to struggle with the implementation of these programs.

So without further ado, I'd like to share with you the great team I have as Commission members to undergo this

process of trying to develop the recommendations that Congress has asked us to put forward and to turn first for introductions from each of the Commission members, to start with my Vice Chair, Dr. David Sundwall.

VICE CHAIR SUNDWALL: Well, thank you very much, Diane. I'm David Sundwall. I am Executive Director of the Utah State Department of Health, and we've been asked to explain to the public why we're here, what perspective do we bring and what we might add to the deliberations which, as you've heard, are quite comprehensive in scope.

I had a long career in Washington, 24 years working in the executive or legislative branch or in the private sector, but since 2005 I've had a dual role. I'm the state health officer, and I'm also the Executive Director of the Department of Health, a large agency that includes Medicaid as well as our traditional public health activities.

What I consider is an important role for me is to make sure that this Commission understands the potential benefit to the public's health of having health insurance through the Medicaid and CHIP programs. It has been well documented that health status improves if one is insured. However, there is a flip side to that, and that is, having insurance doesn't guarantee access to health care or good health. So our focus on access as directed by the Congress is a wise one because we need to look not just at coverage numbers and trends, but also what are we doing to improve population health and individuals' health. So I will be a public health voice as well as someone responsible for the state's Medicaid program.

Secondly, I feel it incumbent upon me to make certain that we understand the point of view of conservative politicians. I am from a very conservative state. It has been called the reddest state. In fact, it is a pretty practical state because, as an illustration of our conservatism, we're one of the 20 states that are suing the federal government on the Affordable Care Act and its constitutionality, whether or not the mandates are appropriate. And I had actually signed as part of our suit an affidavit documenting what we consider an extraordinary burden that will be placed on states that we can't afford in the out-years when the federal co-payments or the federal contribution declines.

So while I don't think for a minute that this Commission should get into partisan politics in any way, we really need to appreciate the thinking and the point of view of conservative states where we don't have an enthusiasm for more federal mandates or requirements or expansions that are going to require us to pay for them at the state level. There are states concerned, and they are legitimate, and we need to factor those in.

The third thing is I do bring a clinical perspective in that while I only practice part-time, I still see patients on a Friday morning in a public clinic. That

helps me because many of the patients I see are on Medicaid, and I can put a face to this public assistance program. When I have to testify at our state legislature, which I do frequently, I can explain to them the individuals and how they benefit and what the needs are, not for it to be just considered kind of a handout. So it's helpful to have that clinical perspective and see the benefits that coverage brings to people who are in need.

And the fourth thing I'll say is that I'm an enthusiastic proponent of health information technology, believe that there is great promise for improving efficiency, reducing medical errors. I'm not sure it's going to save money. Everyone says it's going to save us a lot of money. But, regardless, it's going to improve health care as we implement it.

Regarding Medicaid, there are already some incentives for doctors to get on electronic medical records which are welcome. However, some of the meaningful use requirements are puzzling and are going to be hard to meet. And so we as a Commission, maybe not now but eventually, will get involved in some of the health information technology, which I think is very, very important.

So I'm very pleased to be here. It's an honor to co-chair this Commission with Diane Rowland, who probably is the world's expert on Medicaid, I do not know, among one of the world's experts. So it's an honor for me to serve with her, and I look forward to working with my colleagues on the Commission.

COMMISSIONER HENNING: I'm Denise Henning. I'm a certified nurse midwife. I'm the service line leader for women's health at a federally qualified health center in Immokalee, Florida, which is in the swamp. I'm also the president of the Midwifery Business Network.

I come at this from a provider perspective as far as seeing patients and trying to get them the health care that they need and address their health needs. My goal would be to represent the interests of women, both in maternity care but also in GYN and just general health care throughout the life span.

COMMISSIONER HOYT: My name is Mark Hoyt. I'm an actuary and the national practice leader for Mercer, Government Human Services Consulting. I bring over 20 years' experience advising states primarily on what to pay managed care organizations in a variety of managed care arrangements. It used to be that was pretty much straight ahead capitation. Now there's disease management, primary care, case management that we discussed. I have an interest now in looking closer at some of the newer arrangements that are becoming more prevalent: accountable care organizations, medical home models, bundled payments. What do we even mean when we say some of those words? What kind of assumptions or data is baked into the payments? How do we decide whether those payments are fair, adequate, appropriate?

I also look forward to maybe helping bring some more specificity around just the word access. What do we mean when we say access or try to evaluate it? We probably have to look at it differently for different kinds of populations. Can we reach agreement on exactly how we're going to measure that? Do we have data to measure that? And then being an actuary, data would probably be one of my last key focal points, trying to increase the quality and quantity of usable health care data for all sorts of different purposes.

COMMISSIONER CARTE: I'm Sharon Carte. I'm the Executive Director for the separate CHIP program in West Virginia, and prior to that I served as Deputy Commissioner for our state's Medicaid program. CHIP has meant, as most of you know, such a lot to working families that have either seen the erosion or loss of coverage or found it to be unaffordable. And I feel privileged to be here to be part of this Commission.

COMMISSIONER RILEY: I'm Trish Riley with the Governor's Office of Health Policy and Finance in Maine, and my job over the last 8 years has been to implement a comprehensive health reform package that builds upon Medicaid and CHIP as foundational. And I'm intrigued with system change and how we take our job as MACPAC into this new environment of the ACA. I think it brings real opportunities.

Prior to that, I was the Executive Director of the National Academy for State Health Policy, and I served four different governors in four different roles in aging and was a Medicaid director, and I'm a member -- since its beginning, I think -- of the Kaiser Commission on Medicaid and the uninsured.

COMMISSIONER SMITH: Hi, I'm Robin Smith, and I am the parent consumer of the Commission. Since the 1980s, my husband and I have been foster parents and adoptive parents of children with a wide variety of disabilities, special needs, medically fragile. We no longer are foster parents, but our youngest adopted son is both disabled, medically fragile -- he has vision and hearing impairments -- and he was recently diagnosed with autism. So we are the consumers, and I hope to bring a voice of the consumers to the Commission. I'm also on the board of the Medical University of South Carolina Children's Hospital Family Advisory Committee.

COMMISSIONER ROSENBAUM: My name is Sara Rosenbaum. My career began in community legal services. I spent many years doing national advocacy work here in Washington at the Children's Defense Fund. I went to George Washington University in the early 1990s where I've been on the faculty ever since, and my focus has been on public and private health insurance and access to health care.

COMMISSIONER WALDREN: Good afternoon. My name is Steve Waldren, and I am family physician informaticist. I work for the American Academy of Family Physicians. I

direct our Center for Health Information Technology, so I bring the experience of health information technology policy standards and adoption and am able to checkmark that box on our list of things, but a couple others here around the Commission.

When I think about access in my day job, it's usually about access to data and transparency of data, so I look to help make sure that we get good access to data as well as access to care, to increase transparency and make sure we have effective and efficient care and policy.

COMMISSIONER CHAMBERS: Good afternoon. I'm Richard Chambers. I'm the chief executive officer of CalOptima in Orange County, California. I've been there for the last 7 years running a plan that was created back in 1995 as a public authority in the county to serve Medicaid beneficiaries in the county. Today the plan serves over 400,000 residents of the county, including through the Medicaid program, the CHIP program, and a Medicare Advantage special needs program. So I hope as part of the Commission I'll bring that experience.

Prior to being in Orange County, California, I spent over 27 years working at CMS and HCFA, predominantly in Medicaid positions, in both D.C., Baltimore, and the San Francisco regional office. So I hope that I can bring those years of experience to the table also.

My particular focus I think overall is looking at dual-eligible issues and the integration of acute and long-term care services, looking at health care reform and the incredible opportunity it has for transforming the Medicaid program in serving currently uninsured beneficiaries, and obviously the access and payment issues that impact quality of care to Medicaid and CHIP members.

COMMISSIONER EDELSTEIN: Hi, I'm Burt Edelstein. I'm a pediatric dentist and one of the statutory minority members of this Commission that is a provider. I bring a variety of experiences and background to Medicaid and CHIP issues having been a provider, analyst, advocate, Hill staffer, expert witness for federal court, and long ago a beneficiary of Medicaid.

I am a professor of dentistry and health policy at Columbia University and serve as the founding president of the Children's Dental Health Project, an organization here in D.C. that seeks to improve access to care and oral health for children in Medicaid and CHIP.

I'm acutely aware that Congress specified the inclusion of somebody from the oral health community on this Commission. I've been impressed and gratified by the numbers of times that the Commissioners in their preliminary deliberations have raised issues around oral health. I'm aware that CMS is being closely encouraged by Congress today to attend to the problems in Medicaid services and CHIP services to children with regard to dental services, and I believe that I can bring a variety of perspectives to this Commission, particularly on the unique and sometimes arcane

issues that relate to payment and access specific to children's oral health.

COMMISSIONER COHEN: My name is Andrea Cohen. I've also spent much of my -- almost all of my professional career working in and around the Medicaid and Medicare programs, first as a lawyer for the Justice Department, then working on Capitol Hill as a staffer, working specifically on the Medicaid program, and then working for an advocacy organization and a law firm working on Medicare and Medicaid regulatory issues. Finally, I have landed in the mayor's office of New York City working -- I'm the Director of Health Services where I oversee the city's large and wonderful public hospital system, not running it but serving on the board and representing the mayor and liaising with the public hospital system.

I'm also overseeing the work of our Human Resources Administration which does Medicaid eligibility determinations and runs the Medicaid personal care program in New York City, which has about 3 million Medicaid beneficiaries in the city.

So I've worked on the Medicaid program really at the federal, around the state, and now at the local level and have come to appreciate the important elements that each of those sort of entities brings to the actual experience of being a Medicaid beneficiary and getting services funded by the Medicaid program. So I hope I will sort of keep those different perspectives in mind throughout this Commission, and I'm so pleased to be on it.

COMMISSIONER CHECKETT: Good afternoon. I'm Donna Checkett. I am currently with Aetna. I have had, it seems like a lifetime of experience in Medicaid. I served as a State Medicaid Director in Missouri. I was Director of a Medicaid managed care company and have generally done a number of things related to the payor side of Medicaid and health care.

One of my particular interests, and with Medicaid it is always so interesting -- you know, everything is interesting about it, but my particular interest now really is the interplay between private and public insurance. And as we focus on access in this Commission, what will that mean as we reform private insurance? What does that mean as we expand public insurance?

So I am really very interested in that aspect, in particular, and very honored to be on this Commission. I think we all are, and I am particularly honored and looking forward to working with everyone.

COMMISSIONER GRAY: I'm Herman Gray. I'm a pediatrician by training and I currently serve as the President of Children's Hospital of Michigan in Detroit, a large urban children's hospital with a little over 60 percent of our patients and families that we're privileged to serve being covered by the Medicaid program. It is a large, busy, urban children's hospital with the busiest emergency department in the State and a member of an

academic medical center affiliated with Wayne State University.

My previous experiences prior to what I do now have, I suppose, been consistent with my inability to keep a steady job. I have been an Associate Dean of the medical school. I have been in private pediatric practice for ten years in the City of Detroit. I have worked for the Blue Cross HMO in Michigan for a few years with responsibility for quality, pharmacy, and utilization. I worked for the Michigan Department of Public Health and consultant to their Medicaid Department for five or six years. So I have had a wide and varied background in health care.

I consider myself a child advocate and certainly an important role for me here is to represent the interest of children and those who serve them and their families and to make sure that we maintain focus on their needs and access to quality care.

In the City of Detroit, I can literally count on one hand the number of pediatricians who are in a private practice setting, not employed by a large employer like ourselves, the Children's Hospital, largely because it is absolutely impossible to practice pediatrics or primary care medicine in our city with current provider rates.

I have a particular interest in children with special health care needs, of course, as a Children's Hospital person and look forward to the work that the Commission does, and I am really very pleased to be part of it.

COMMISSIONER MOORE: I'm Judy Moore. I'm currently a Senior Fellow at the National Health Policy Forum here in Washington, D.C. I'm a retired Federal Senior Executive with many years of experience in the Department of Health and Human Services and several stints in the Medicaid program through 30 or so years, going back to some of the early days of the program.

I'm the co-author of a history of the Medicaid program and my interest here on the Commission will relate in a number of areas, but I will be particularly interested in the impact on program operations, or the interaction of operations and policy. I think developing better Medicaid data, information, and systems is an important priority for all of us, and learning as much as we can about what is working for States and sharing that widely. So I very much look forward to the deliberations of the Commission.

CHAIR ROWLAND: And I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation, and since 1991 the Executive Director of the Kaiser Commission on Medicaid and the Uninsured. So I've obviously been looking at and working on the issues as a researcher and as an analyst of how do you improve care for the vulnerable populations in the country? How do you make the Medicaid and CHIP programs work more effectively to provide that care? How do you improve enrollment? And once people are enrolled, how do you connect them to the best quality

care at the most reasonable cost?

And I think those are all the charges that we have before us as this Commission and I am delighted to be asked and to serve as the Chair and to have this great group of colleagues with me in this endeavor as we launch really the first effort the Congress has put forth to take an examination of the Medicaid program and the CHIP program, equivalent to the work that MedPAC and previous commissions have been doing on the Medicare program.

And I am especially pleased that as a Commission we have been able to begin to recruit a fantastic staff, and we started by naming Lu Zawistowich as our Executive Director, and I would like to introduce her to you now so that you can see the person who is going to organize all the work that will make this Commission, I hope, a valuable contribution to policy development at the Federal and State level. Lu?

EXECUTIVE DIRECTOR ZAWISTOWICH: Thank you, Diane. I'm so pleased to be here. I've had over 20 years of experience in the Medicare-Medicaid programs and in the private sector and it is really an honor to be working with you and all of the Commission members.

At this point, I'd like to ask our staff to stand. We've been very lucky to recruit a wonderful group of people that will be supporting the Commission, and they are Christie Peters, coming to us from the National Health Policy Forum, who will focus on dual-eligible issues; Chris Peterson from the Congressional Research Service focusing on eligibility, enrollment, and benefits; Patti Barnett coming from OMB, who will focus on finance and budgeting issues; April Grady, also from the Congressional Research Service, who will focus on data issues, enrollment and eligibility; Lois Simon, starting yesterday, coming to us from New York Medicaid, will focus on access to care issues; Cindy Shirk, a consultant to the Commission, who has helped us in standing up the Commission; Matt Chase, who is our Chief Information Officer and who is responsible for our website and getting us up and running and our e-mail.

And I would also like Bruce and Jenny stand, and I know I see Molly back there somewhere, but she is hidden for the moment. Bruce Steinwald, our consultant coming from the GAO, helping us to stand up the organization; Jenny Kenney from the Urban Institute, serving as our Senior Research Advisor; and Molly McGinn-Shapiro, Special Assistant to Diane Rowland and working with us to, again, help stand up the Commission.

It's been a bit of an adventure as we've started with nothing and moved forward to create a staff and a structure so that we can begin our deliberations. We view our role as staff to the Commission as supporting the Commission in their policy work, in their options, and in the development of their recommendations. Through the deliberative process, we will come up with options for them to consider, recommendations, and ultimately reports that

the Commission will issue to the Congress.

We take this deliberative process very seriously, and one of the key elements of the deliberative process is that we consult with key stakeholders and States. We will embark on this effort by working with the key associations representing States and providers, the National Governors Association, the National Council of State Legislatures, the National Association of Medicaid Directors, but we also believe that it is important to really understand how Medicaid programs are working, how markets are working at the State level, so we will also go to the States and begin to understand how those health programs work. Through these efforts, we'll be providing information to the Commissioners in their deliberative processes.

We, again, are very honored to be part of this. Thank you so much.

CHAIR ROWLAND: Thank you. And so without further adieu, we are going to begin our deliberative process by asking our first panel, Genevieve Kenney and Julie Hudman, to join us to begin our discussion of access for Medicaid and CHIP enrollees, to really begin to look at what some of the issues are in the research literature surrounding access to care for Medicaid and CHIP beneficiaries, what additional work is needed. This is an area that clearly was identified. It's in our title as a Commission, but it's also very clearly in our statutory responsibility to review where there are shortages, to look at what the studies have told us about access to care, to look at where some of the advances are that are improving access to care, as well as the challenges.

And so we've really been delighted today to bring our Senior Research Advisor, Jenny Kenney, to the table. Jenny is an economist with over 20 years -- that seems to be a theme here --

[Laughter.]

CHAIR ROWLAND: -- conducting research with a special focus on children and access to care, and Julie Hudman, who runs the D.C. Medicaid program in the Department of Health Care Finance who has on-the-ground experience as well as a background with great research experience in looking at access to care for vulnerable populations and trying to manage their care.

And we have asked them to set out some of the key issues for us and then we will entertain questions of them so that we can begin to help shape this Commission's agenda around access to care.

Jenny?

DR. KENNEY: Thank you, Diane. I, too, am delighted to be here today as the Commission begins its important work around access to care and Medicaid and CHIP.

In the time I have, I am going to highlight some issues that the Commission might want to consider in its deliberations, both with respect to access to care in Medicaid and CHIP and regarding data and research gaps.

As a starting point, going to first principles, relative to private coverage, Medicaid and CHIP tend to have a richer benefits package and less cost sharing, but also lower physician payment levels. As a consequence, Medicaid and CHIP coverage may offer greater protection against a high out-of-pocket cost, but with more restricted access to providers relative to private coverage. So in light of these trade-offs, it's not clear a priori whether to expect private or Medicaid coverage to offer greater access to care.

Moreover, access likely varies across States since Medicaid and CHIP programs differ from State to State along a number of different dimensions that could affect access to care, such as which benefits are covered, what type of cost sharing arrangements are in place, what type of managed care arrangements are implemented, what the provider payment policies look like.

Despite this rich diversity of experience across the country in terms of policies, we have actually pretty limited information on how access to care varies across the 51 different Medicaid and CHIP programs in this country, with most available research examining access to care at the national level or zeroing in on a particular State.

I'm going to turn now to some broad-brush top line findings that we do have on access to care in Medicaid and CHIP and with the proviso that the selected findings I'm going to share in the short time I have don't in any way, shape, or form fully convey what's actually a complex and rich picture of access to care in Medicaid and CHIP.

I'm going to focus on what we know from national survey data, and when we look at national statistics, we find fairly strong access to routine primary care in Medicaid and CHIP, especially for children. Not surprisingly, populations covered by Medicaid and CHIP have much greater access to care along a number of different dimensions compared to the uninsured, but they also have primary care access rates that are comparable to and in some instances better than those with private coverage, especially when we focus on low-income populations.

At the same time, however, relative to those with private coverage, Medicaid enrollees have higher rates of emergency room use. They also have a greater reliance on safety net providers. They experience higher rates of potentially avoidable problems, such as ambulatory care sensitive admissions and dental caries. And they report more problems gaining access to specialty care.

Importantly, however, these access gaps tend to narrow when we take into account or control for the different health, economic, demographic, and social characteristics of the populations that are served by different payers.

So if we turn to some of the data, this figure shows how the presence of a usual source of care and unmet medical needs vary for children and adults across three

different payor categories, those with Medicaid or CHIP, those with private coverage, those who are uninsured. You see that for both children and adults, the uninsured are substantially more likely than those with public coverage to not have a usual source of care and to say that they had an unmet need for medical care in the prior 12 months. Also for these two indicators, the rates are almost the same for children with Medicaid/CHIP coverage and those with private coverage.

Where we see more divergence between private and public coverage is for the adult population. We see that the proportion reporting not having a usual source of care is similar, but that publicly insured adults are more likely than privately insured adults to report that they had unmet medical needs. This differential could be explained in part by the fact that publicly insured adults have much greater health problems than those with private coverage, on average, and hence are likely to have greater health needs. But it also could be due to restrictions in benefits or access to providers in Medicaid relative to private coverage.

If we look now at the usual source of care for children, we see that for both children covered by Medicaid or CHIP and those with private coverage, a private doctor's office is reported to be the usual source of care for the majority of children. But children with public coverage are much more likely to rely on community health centers and other clinics as their usual source of care.

Consistent with other findings, the uninsured are much less likely to have had a physician visit in the prior 12 months relative to those with private or public coverage. We see Medicaid-covered adults being more likely than privately insured adults to receive physician visits, and again, that may reflect a greater need for health care on the part of Medicaid-covered adults.

And for children covered by Medicaid or CHIP, the receipt of physician visits is similar to what we observed for children with private coverage, and in studies that have drilled down to look at receipt of well-child care, we have found that children enrolled in Medicaid or CHIP are actually more likely to receive well-child check-ups compared to low-income privately insured children.

When we turn to dental visits, we find that privately insured adults are less likely than publicly insured adults to receive any dental care, whereas dental care receipt is quite similar for children whether they have public or private coverage. The different pattern found for adults and children could be driven by a number of factors related to the benefit coverage for adults that is optional in Medicaid but mandatory for children.

The last service category I want to look at is emergency department visits, and here you see the substantially higher use of the emergency room or reliance on the emergency room among Medicaid enrollees compared to

both those with private coverage and those who are uninsured. Again, both children and adults covered by Medicaid tend to have more health problems, so that is one of the drivers of what is going on here. And one study attempted to control for a number of observed differences between those with private and those with public coverage and found that about half of the difference in emergency rooms could be explained by those observed characteristics. But that still leaves a large amount of emergency room use that we can't explain through observed characteristics of Medicaid and other payor groups.

Importantly when thinking about access, as with other payor groups or other payers, there are questions about access to care for minority populations in Medicaid and CHIP. For example, one study showed that Medicaid-covered children with asthma who were Hispanic were about 40 percent less likely than their non-Hispanic white counterparts to have had a specialist visit for asthma. And when we look at rates of emergency room use, they appear to be 36 percent higher for African American Medicaid enrollees as opposed to white Medicaid enrollees. But I want to point out that there is also a black-white differential in emergency room use found among those who are privately insured, so the underlying factors may not be specific to Medicaid.

So that quick tour of some statistics that shape some of what we know about access to care in Medicaid and CHIP I think illuminates the fact that when we are trying to assess the state of knowledge about access to care in Medicaid and CHIP, that while we have a number of individual studies and a number of statistics, we really don't have an ongoing comprehensive or systematic assessment of access to care in these two programs. There are large gaps in our knowledge base about access to care in Medicaid and CHIP. And particularly, we lack information on how access to care looks in particular States and across different local areas.

One of the limitations with existing household survey data is that they seldom have large enough samples to support State-level analysis on access to care in Medicaid and CHIP for all States. Therefore, we really don't know whether any pattern that we are finding at a national level, in national studies, would be found in all States or in just a subset of States. We don't know much about variation in access to care across States.

Another constraint with household survey data is that unless it is merged with administrative records, it can be difficult, if not impossible, to separate out Medicaid from CHIP coverage and to know whether a given Medicaid or CHIP enrollee is in a capitated managed care arrangement and what benefits and cost sharing they have.

Another potentially rich source of information on access to care which I haven't tapped in today's presentation derive from administrative records and from ongoing State efforts to track access to care in their own

programs, and I know Julie is going to be focusing on some of these issues in her presentation. But I also want to point out some gaps that we have in those data. Since much of the CHIP population and, as Diane indicated in her slide on managed care penetration in Medicaid, much of the non-disabled, non-elderly population in Medicaid are both enrolled in capitated managed care arrangements, that means that the publicly available Medicaid and CHIP administrative data on service use don't include information from many of those who are enrolled in these programs across the country.

Going forward, the Commission may want to address the following types of issues around access to care. Which access measures to track. How broadly to measure access. How deeply to go in particular service areas. Whether to include outcomes as part of the tracking. Whether and how to prioritize different measures and specialty areas. What data sources to use. And what measures to include as part of a real-time early warning system.

Which groups to use as a point of comparison. What external benchmarks to use. Should the comparison group be all those with private coverage, or should it just focus on those who have employer coverage, not those who have non-group coverage? Should it focus just on those who have low incomes and look more like the Medicaid population in terms of their characteristics?

Should considerations of access to care in Medicaid and CHIP take into account the fact that the underlying health, social, and economic circumstances of these populations vary so much across different payers? Which subgroups should be tracked within Medicaid and CHIP? Besides looking at adults and children separately, should the disabled be tracked separately? Should tracking be done for subpopulations who have chronic health care problems? For those from different race and ethnic minority groups? By primary language? Should comparisons be made to access differentials found for a given subgroup for other payers? If so, what are the changes in data collection needed to support these efforts?

And for what geographic units should access to care be tracked beyond the national level, and at what periodicity? What do we need to know at the national level? What about the State level?

And as if that wasn't enough on your plate, what do we need to know about the underlying drivers that are affecting access to care in Medicaid and CHIP? The Commission may want to consider tracking factors, such as those listed here, that may affect the willingness and availability of a range of different providers to participate in and provide care to populations covered by Medicaid and CHIP. You are going to be hearing more from Peter Cunningham and Andy Allison on those topics, so I will move on to other potential drivers that may need to be part of the tracking and analysis of the Commission.

The second set of factors would include or could

include benefits and cost sharing provisions for different populations in each State. In principle, these should not pose access barriers for children covered by Medicaid because of the richness of the EPSDT benefit package and the limitations on cost sharing to nominal levels, but States have more options over the benefits package for adults covered by Medicaid and for children in separate CHIP programs. As a consequence, for example, Medicaid-covered adults don't always have access to dental care and children in separate programs, for example, with special health care needs may experience access problems because of limitations, say, in benefits with respect to certain therapy services.

Finally, it may be important for the Commission to track other types of barriers that could impede access to care in important ways for Medicaid and CHIP enrollees that reflect transportation barriers, language issues, issues with respect to cultural competence, and that may be very specific to the populations targeted by these programs.

In closing, I want to draw attention to a number of policy changes associated with health reform that could have profound effects on access to care in both Medicaid and CHIP. First, the maintenance of effort requirements under the Patient Protection and Accountable Care Act of 2010, which constrain States from cutting back on eligibility and enrollment, may cause States, given their budget situations, to cut Medicaid spending -- to look for other ways to cut Medicaid spending, such as cutting out optional benefits or reducing provider payment levels.

Second, health reform mandates Medicaid fee increases up to Medicare levels in 2013 and 2014 for primary care services provided by primary care physicians. The proposed fee increases are financed by the Federal Government for those two years.

Third, health reform contains increased funding for community health centers, which could affect access to care in communities where those new investments are made.

And finally, health reform includes a major expansion of Medicaid coverage to more adults beginning in January of 2014. Ultimately, the Congressional Budget Office projects that by 2019, another 16 million enrollees will be added to Medicaid through a combination of this Medicaid expansion and what is assumed to be increased take-up among the already eligible for coverage. This increased demand for services within Medicaid could have profound effects on access to care, particularly in the areas where enrollment increases are projected to be highest.

So with that, let me close and turn the mic over to Julie. Thank you.

CHAIR ROWLAND: Any direct questions for Jenny before we go on? Let's go on with you, Julie.

DR. HUDMAN: Good afternoon. I'm very happy to be here. I want to thank Lu and her staff for asking me to join you all.

I'm going to do something a little bit different

than what Jenny did. I've sat in that seat, as Diane said, as a policy researcher and analyst and have some experience in state government, and have spent the last four years actually having the honor to work for Mayor Fenty and the last two years actually running the Medicaid and CHIP program here in the District.

And so, I wanted to give a little bit of, I think of it as color, next to the data of some of the access issues that we've confronted. I'm not going to show you a lot of data. I'm going to just really kind of tell you a little bit of kind of my frustrations, especially coming from more of the policy world and being plopped down and running a program, and some of the things that, as the country moves forward in expanding Medicaid to all the populations, some things that I think that we should all be looking at and that would be great for MACPAC to look at.

So just a really brief, this really isn't about D.C., but I wanted to give folks a context who aren't here. This department that I run started a couple years ago and actually, on October 1st, it will be two years old. And so, I feel for Lu in trying to bring up something new. It's complicated.

But it holds the Medicaid program and also the CHIP program and also a program called the Alliance, which is our state-only funded program which kind of covered all the populations that Medicaid previously left out, and will continue to cover a population that is left out, including the undocumented immigrants.

So everybody in the District is eligible for Medicaid or the Alliance under 200 percent of poverty, and we also go up to 300 percent for children and pregnant women. So we have kind of done the coverage thing, and so we're one of those states who isn't afraid of some of the mandates that are in the bill. We're very excited. We're way over what the mandates are.

So we cover over a third of the population of the District, and it's about 225,000 enrollees right now. Our budget is \$2.12 billion and most of that is federal because of our great match rate that we get. At one point when they decided the Federal Government wasn't going to give the District money anymore, they actually gave us money now through our Medicaid program. So this is the main funding source that we get from the Federal Government. But we, right now, are matched at 79 percent.

And all of this coverage that we have and we've been able to maintain has led us to have the second best uninsured rate in the country, right behind Massachusetts. We just worked with the Urban Institute this past year to do a survey. We're at 6.2 percent for adults and at kids we're at 3.2 percent. So we're very proud of our ability to actually provide the coverage to the population.

As we were thinking about access, and like I said, I think when you look at health care and you look at the Medicaid program, it's coverage, access and outcomes. And

so, we've done a really pretty good job on the coverage piece. We're different than a lot of other places where small folks are, you know, there's not some of those situations associated with stigma or ability to enroll in programs. We've kind of figured that part out.

Access is kind of the first things that we looked at. When we were developing the new department, we had to have performance measures for our department. In all my good years spent as a researcher, I knew that there was a problem with getting providers to enroll in Medicaid and to serve the population.

And so, we started asking questions of, well, we should actually increase the providers who serve our population. So we did a couple of things. One thing, we were fortunate enough at the time to be able to raise our rates. So right now as of today, we cover 100 percent of Medicare for primary and specialty care. We're one of 11 states that do so. As of October 1st, we go down to 80 percent because of budget issues. So we have a few more weeks at 100 percent. We're really proud about that.

The other thing that we did immediately is, you always heard that the administrative burden of dealing with the Medicaid program was huge, so we have a brand new MMIS system and that's really our payment system, and providers can enroll online, they can submit their claims online, they can immediately see if it's going to be paid. If they submit it by Thursday night, they get paid the following Friday.

And so, those two things have helped us enormously in dealing with having providers participate in the program. It's the first thing I did, is have a provider town hall and it was really packed the first time I had it and it was scary. Then I've had one recently and literally can't get anyone to come. So I'm like, okay, that's going to be my little study of how we're doing with providers.

But the third thing we said, well, let's increase the number of providers we have in the program. So a good researcher, I said, okay, well, how many do we have now? Well, I have 6,823 enrolled providers in the fee-for-service program. And so, I have 2,700 that are primary care providers and I have 4,000 that are specialists.

And then I said, well, do they all see patients? Well, of course not. So active providers. 3,500 have actually filed at least one claim in the past year. And then about half are primary care and half are specialists.

So I would rather see how many are kind of actively doing it a lot, because then you start asking, well, a community health center, that's all they see is Medicaid providers so they provide a lot of claims. But if I have a private doc and they do -- because they don't really see Medicaid patients, but they do every once in a while or as a favor, I mean, they really shouldn't count the same. Right? It should be weighted a different way. Well, that's absolutely too complicated for us to figure out, so

we just have to stick with someone who's actually filed a claim in the past year.

But then the question said, well, what do we want to raise it to? What is the right number of Medicaid providers you need to serve your population? And talked to some researchers. There is some matrix or some ratios that people give for a state or a population area. You need so many primary care providers per 1,000 population. And I actually don't even know what the number is. But as we know, it doesn't quite work with the Medicaid population.

And also, you assume those providers are private providers who get private insurance. Once you start talking about Medicaid again, we have some providers who see all Medicaid and then we have a lot of providers who see a little bit of Medicaid.

So we picked a number that we said we were going to increase to. I don't really know if it's meaningful, but I think the right thing is trying to bring the providers in. But I think as we look forward and we look at states like Texas or states that are going to do enormous expansions, I think, if I'm sitting in that seat as a Medicaid director, I want to know how many providers do I need, how am I going to get them, but how many do I need? What is a proxy? And I think trying to find a measure for that would be a very important thing to do.

Managed care is a different situation. We have most of our population in managed care, and a lot of things that we talk about when we look at our managed care population in my plans, is I say, you guys at least need to provide me two things. You provide me a network that you already developed and you provide me care management. And if you don't provide me those, then I don't know why I'm in a fully capitated managed care.

And so, we decided to do some oversight ourselves and we did a secret shopper initiative with our managed care plans. And what we did is we went to our enrollment broker, which every state has to have, and we got the provider directory that they created for the enrollees when they were choosing which plan they had.

We took that provider directory and then my staff called all the providers -- not all the providers -- they called about 500 primary care providers and said, can I have an appointment? They had a Medicaid number, the whole bit. And we actually found that only 13 percent of the primary care providers met the criteria and only 9 percent of the OB/GYN. They had to schedule an appointment within 30 days for a primary care visit. OB/GYN was, I think, 15 days.

We talked to the plans. They said, oh, well, the data is wrong, the numbers are wrong, there was a problem with the computer, and then as in running a program, you said, well, why am I paying my enrollment broker and my plans money to send the data over, to produce these provider networks that we give to the enrollee, and they're supposed to be making some informed choice about where their provider

is. And then all the numbers are wrong and that doesn't work.

And they said, well, if they just call the plan, we have staff that helps make sure they get a visit. So we worked with them. We cleaned up the data. The provider network directories are better. But what I think once again the story says is, it's only as good as the data that we put in. It's not super-meaningful to have people choose and have an enrollment broker and help them, if what they're choosing off of means nothing.

And it's certainly not helpful if I'm a mom and I have my provider network directory and I'm sitting there calling and I'm getting, we don't take Medicaid, you have the wrong number. This is the Washington Hospital Center's emergency room, you know, I'm not taking new patients.

So that kind of access issue -- we cover a lot of folks, but we're relatively small. One of our plans is a home-grown plan and they said they worked these things out. Well, we also have a super strong community health center network and that's really who they work it out with.

And so, I feel like we don't have a tremendous access issue because of that on the primary care side, but at the same time, if you're expanding a program as big as California or Texas or, New York has already expanded, that's going to be a major, major issue.

The second thing I wanted to bring up when we think about access and we think about Medicaid is really what we want our managed care organizations to do. And like I said, some states, Oklahoma, doesn't use MCOs at all. So there are plenty of states that will not go down that path, but many states do, and ever since I began working in this area, I've worked on managed care issues, and to be honest, I'm pretty skeptical sometimes of managed care organizations and I've worked hard with the ones that we contract with to both learn what they do and improve what they do.

But I think what we need to have a discussion about is, what are we asking our managed care organizations to do? I had at one point three plans. I have one special needs plan for kids and then I had three other plans that served our basic claim families and some childless adults.

One is a national plan and two were local plans. The local plan that was community health center based we no longer contract with, and so we just have one local plan and really one national plan.

A lot of us who have worked in Medicaid for a long time know that Medicaid is not a normal health insurance program. That's not how it was designed on purpose and it's not the way that it's administered and run. So as we expand to a bunch of new population, I think there's going to be enormous tension, and I can see it between my two plans, of what is expected of them. What do I do with translation and transportation?

Now, translation, some of them understand that from an access point if they're serving different

populations or different cities, but as an entitlement? As something they have to do in a certain way is very different than, oh, yeah, we have someone who speaks Spanish that you can talk to.

And so, I think that conversation needs to happen about what we are asking our MCOs to do, what a state is asking them to do, what are they going to wrap around, is that going to be inside a managed care plan or is that going to be outside of it? Because there's definitely different approaches even just in my little world the two plans have because of where they're coming from.

And kind of building off that, what I said before with managed care was, I think that they offer two things. They develop the network, they set up the contracts, and they set up the rates with the providers.

The other thing that they're supposed to do is manage care. That has been a struggle over the past two years of understanding what managed care means. I think what the MCOs we work with think managed care means is utilization review and managing costs. And, of course, that's part of it. That's a very important part of it. But the other part that I think is there is that they're supposed to be providing something to the populations that need extra help.

We had a case that I want to tell you about that is still ongoing. I can't use the full name of the baby, according to my lawyer, for HIPAA reasons so we'll call him Baby A. But I got a call from the mayor's office this summer and said, a Medicaid baby died, was in one of your plans and was turned away from a specialty clinic because it didn't have the right referral and it died that night, and so, would you look into it?

So we started an internal kind of root cause analysis on this case and we learned a lot. The MCO that I said we no longer contract with, that mom transitioned to a new plan about a week before she gave birth. She gave birth to twins. They were in the NICU for 15 days. They went home. The baby was on an apnea monitor, and had a visit to a specialty clinic to look at the apnea monitor and how the baby was doing.

The health plan went and had one visit in the hospital with a subcontracted nurse company. There was a different subcontracted nurse that went and visited once at the home. And there was another contract with the DME provider that put the apnea monitor into the home. The DME provider came out because the mom called because the apnea monitor was going off and she thought something was wrong with it.

And he said, no, your baby is setting off the apnea meter. She said, well, it's good, I have this appointment the next day. The DME provider did not tell either one of the subcontracted care managers that the apnea meter was going off, did not tell the health plan. None of the three actually knew the other three were operating in

this system.

The mom showed up to the clinic the next day, the specialty provider, and was turned away or told to wait because she didn't have the right referral, and the baby died that night. The baby was 26 days old.

And so, I met with the health plan and had a very interesting conversation about the role of the health plan, and they wanted to talk a lot about the role of the mom, and I said I didn't have the hundreds of millions of dollars contract with the mom. I had it with the health plan and I wanted to talk about the care management.

And so, we have been talking for a long time, the last couple months about that, and we are waiting for the city to have its infant mortality case review and to look at this. These things, things are going to happen and the health plan can't do everything they're supposed to do, but this was a high-risk pregnancy, we have a perinatal collaborative, and we're focusing on birth outcomes in this city that has a horrible infant mortality rate, and I'm paying a plan who says it's really not their job.

And so, as we expand Medicaid to all these populations across the country, again I think we need to decide what is the job, what are we asking them to do? And as plans who maybe get into this business who have never served the population before, they're going to have to know, we can call it compliance or we can use all the different words we want to use, but I think it's important to think these are populations that maybe aren't very familiar with either how to use the system or plans who aren't very familiar how to serve them.

Like I said, it's a case that's still going on. We've made changes, the plan has made changes. Happy to say that they're only using one nurse care management that's going to follow the mom from the hospital to home, and their DME provider is required now to report back. And so, we're making all the changes that we can make within our little system. But I do think it's illustrative of some of the challenges of managing care generally and what that means and serving the population that we serve.

And then finally on this is another thing about setting rates. I know that payment rates are going to be a big part of this. One of the things that I learned about how we set rates for our managed care organizations is we do it annually. Every year our actuary gathers up all the costs from the managed care plan and the costs from last year are built into the rate for this year.

My understanding is that is part of it being actuarially sound, which is what CMS requires. However, to me, it seems like that the incentives aren't lined correctly if all the costs that you had the year before are built into your base rate the following year. We have pay-for-performance. We kept 1 percent back and have certain categories where the plans can get the money back.

We don't have super high rates and I don't think

it's necessarily that's the issue. But if we're doing annual contracts and we reset the rates every year and all the costs from the year before are built in the base rate, if we really think financial incentives will work, it doesn't seem like we have the financial incentives right, if we're just building in costs from the year before.

So we're trying to think of new ways that we can do things that will actually create incentives for plans to work year after year, as we know the Medicaid population can come off and on the program. Hopefully going forward with everybody under a certain income there will be less churning and things happening.

But I do think we need to think about, in managed care, as we're thinking about on fee-for-service, in setting certain rates at 100 percent of Medicaid, which is wonderful. In the managed care setting we need to think about how those rates are set and what incentives we're putting in there moving forward.

And finally, I just wanted to touch on one issue. The Commission doesn't have outcomes in its name. It's interesting because that's what we all really care about, right, is that people have better health outcomes, and when this new agency was started, I was an advisor to the mayor at the time and he asked me, should we have a new agency, like you're part of Department of Health, what does it matter?

And I said, well, it's a \$2 billion budget and it's like kind of buried in the Department of Health and they've got to worry about rats and food inspections and they have a lot of things they've got to do, and you've got like a third of the city and \$2 billion spending. And he said, well, what am I getting for \$2 billion? And I said, well, we're covering 200,000 people with health insurance. And he said, but are they healthier?

And I said, I don't know, I really don't know. And what's frustrating even two years later is, I still really don't know. What I know is what I can measure and what I can't measure. The chairman of the City Council who has oversight of my agency said, I want to know how many people have cancer.

I said, I can't answer that. I can tell you how many chemotherapy sessions I've covered and I can divide it and kind of link it back to the people, but I can't tell you necessarily what kind of cancers. Because I have payment data. That's what I have. I have who I paid and when I paid it. And sometimes I pay it six months, nine months later.

With Electronic Medical Records and some other things that we're doing, I'll have better data. The other data we use is HEDIS data with our plans. Most of it is process measures, access measures, very few outcome measures. And so, I think it's really challenging. But I actually think it's challenging for people to really kind of step up and say, we really are trying to prove outcomes.

We've got to get coverage first. Then we've got to make sure access is there, and outcomes is kind of the last. Right?

But even changing our mission as a new agency was like a big deal and people are like, we can't talk about outcomes. We can't be held to that. These people have complex lives and other things happen. And I said, well, if we're going to spend the money, we should at least try to improve the outcomes. Right? That should be a goal.

So I just wanted to end with looking at a couple of the measures that we do have and then to kind of not to end on a downside, but to also talk about even if we have the measures, we're not really sure what it's telling us.

So the first one is, we're really proud of this measure with our kids. It's a HEDIS measure. Depending upon the age, we have almost 92 percent of kids are getting the timely wellness checkups that they should and that's what Jenny presented, that the Medicaid program does it really well. We have a huge emphasis on that.

Even with kids with asthma, and this is people actually with asthma, we have 90 percent have appropriate medications use. If you skip that next one and go to the bottom one, but I also have 20 percent of people with asthma visiting their emergency room, and that's not even a positive outcome. It's sort of a negative outcome, right? So we can't even measure really a positive one. We're measuring a negative one.

And then our own Urban Institute studies reported that 25 percent of people on Medicaid said they had, quote, access issues. So I think what's hard for us and what's hard for you all, as you all are charged with reporting back to Congress how Medicaid is doing on access, is really just the different data sources that we have and the different stories that it tells, and, I guess, probably the frustration we all have of really understanding if we're really, bottom line, improving health outcomes for folks.

Like I said, I think it's extremely important and we've got to start with gathering the data that we have and looking at it and trying to tell a story, but I would want to think about, you know, is there a better systematic way to do this? Like I said, I'd love to help and just want to thank everyone for having me here.

CHAIR ROWLAND: Thank you so much, Jenny, Julie. And now we'll open it up for comments, questions by the Commissioners. Sara?

COMMISSIONER ROSENBAUM: Thank you very much, both of you. Julie, I have some questions for you. Similar story, actually, from Chicago a few years ago. This is not an unheard of story. Same kind of problem, sort of a care breakdown. I wonder whether you might talk a little bit about, once you did the root cause analysis, what kinds of services in retrospect you might have contracted for that, in your view, we're missing, the kinds of things that should have been in a contract that maybe were not, in terms of

performance expectations.

DR. HUDMAN: Sure. I just want to take it one step higher, Sara, to answer that. What was the most frustrating and the most upsetting to me about this case is that is the attitude of the plan. And I've actually never been more mad in a meeting in the four years I've spent in this job than I was in this meeting.

It finally got to the point where I had to say, we are talking about a dead baby, because everyone was talking about what's in the contract and what they're obligated to do and things like that. And that was what I just -- it was really hard, and I think if I had the staff here -- and this is the top of the staff so they didn't even have the ability to pretend like they cared and to say all the things that they should have said.

So it really just was striking that wow, we just totally have a different vision of what the role is. So once we got past that, which was hard to get past, the second piece was really the problem with, and everyone who has ever run a business or a government organization, of constant contracting generally.

So we contract out to the MCOs and I'm real happy that I don't have to deal with some of the things that they do. But I also don't know everything that's going on. And then they turn around and subcontract out. So, I think, number one, we have to take a better look at just even who they're subcontracting out to and what that means.

And then I think when we went back and looked at our contract, we weren't very specific on exactly what should be happening around case management. Some of our measures were how many case management staff do you have per population. I mean, some of our measures just didn't really get at what we were trying to do. They weren't very specific on visits and how much you should visit and what it means. And they weren't very specific on reporting information either to us or to even each other.

So I think real simple would be a closer look at the subcontracts and then it would have been a closer look at the communication flow. I mean, I just think when you step back and when they were walking through it, they realized, too, having two separate nurse care management companies, one that's a hospital-based one and one that goes in the home, just doesn't -- and then you didn't even require them to talk to each? So they quickly changed that and just have one.

So at least there's a hope for some continuity between that when the mom goes home with the baby. So I think really still having the conversation about what it really means to have case management. And we are actively -- and I've been very clear with the plans -- we are actively talking to our community health centers about the home health option that's in health care reform and really taking some of the money that is going to the plan, which we thought was paying for our case management, and giving it to

the provider and bypassing the plan.

This is not, again, to bash on the plans. This is really just trying to figure out where the best place, in the limited resources you have, to put the dollars where you think you're going to be able to get the outcome you want. And so, it's good for us to have that conversation because the plans are involved in it, too, and so we can kind of figure out what makes sense.

But I think it's expectations and then I think it's some of the contracting issues and communication.

COMMISSIONER ROSENBAUM: If I could just ask one follow-up question? The follow-up question is, from your own agency's perspective and thinking a lot about the constraints on Medicaid programs, what level of performance oversight might you have wanted in the agency that you lacked in terms of investment, direct investment of agency into agency resources, for you to be able to manage better?

DR. HUDMAN: When we started this agency and we pulled it out of the Department of Health, what I tried to figure out is what is the right number of staff and how many staff do you need? And so, we worked with some states. Andy from Kansas helped us and other states, and it was impossible to figure out, and everybody gave me different advice. Everybody had different -- some were parts of smaller agencies or bigger agencies or some didn't have as much managed care or less managed care.

I think what's really hard coming into this and what other Medicaid programs as they expand are going to be challenged, is really some of those. I mean, we want to talk about access to care and things like that, but really some fundamental things about where should you put your resources?

We have a lot coming down on fraud and abuse. I've had to put a lot more resources, which is important, believe me, because we have a lot of fraud and abuse around home health and DME providers here in the District and across the country. But is that really where I want to put all my resources, is fraud and abuse? I mean, if I don't have proper oversight of our managed care contracts or I don't have enough policy staff to write all the state plan amendments and the waivers and things I need to do to comply with federal regulations coming down, that by far has been the hardest decision. Besides hiring people and everything else you have to do is where you put your resources.

I changed it when I came in. Managed care, the division that did managed care did it by subject area. So we had people who did behavioral health and people who did kids and different issues. So we changed it and I at least had one person who was in charge of each contract. And then I had a couple of people over all of them. So we actually redid it.

And we know so much more than we ever did and I think we are doing a better job, but clearly we have a lot to do. So I guess I don't have a good answer except for

it's hard to balance and CMS really does kind of set some of it. Where you start set some of it, how many staff you have, and then some of the priorities coming down from CMS, and requirements that we have to do kind of sets the other.

COMMISSIONER RILEY: Hi. Sorry, I had to step out. I'm intrigued with, as a Commission, how we ought to approach the many issues we've been confronted with on Medicaid managed care and instruct, cynically, that 10, 15 years ago Medicaid managed care was the silver bullet. Now the new one is payment reform and ACOs. In principal, ACOs address the kinds of issues you comment on because they're about keeping a population healthy.

How much should we spend our efforts looking at how to fix the Medicaid managed care issues that you raise and how much should we try to pivot and think about a new day of payment reform, accountable care organizations, and be in the front line of that lest it become like managed care did, sort of a promise that wasn't realized?

DR. HUDMAN: I want to be real clear. I'm not even talking much about fee-for-service because I don't even know really what's happening in our fee-for-service program. I'll be real honest. I know how much I spend. And so, that definitely is not the answer. And like I said, some of the models that we're thinking about are going to pull -- it's not necessarily an alternative to managed care. It might be an alternative to fee-for-service where there's nothing there.

It's really hard, at least in the District, and as I talked to some of my colleagues, to really make wholesale changes. And when I talk to some people who do it, it's years in the making. If 2014 is looming around the corner and all the things that we have to do, the idea that the payment reform is going to be happening at the same track, some states are already there and doing it and some of us aren't.

I guess what I would want is I'd want more data and more information, but I think having more guidance from either experts on what the right way -- kind of a roadmap. That's the hard part. So we can talk about the data. ACO sounds great or this sounds great, but actually having the roadmap of how you get there? Here's the steps you need to take, kind of an implementation roadmap. That's where I'd love to see more resources and time spent and kind of set up where if you look like this, your program looks like this, and you think you want to get here, this is the steps you have to take.

A lot of the research and policy work where we get that kind of guidance is from the consultants that charge a lot of money and we have to have an RFP and we have to find the money to pay them. And so, that's the kind of guidance that, at least in my perspective, what states could use as we're trying to navigate all these things coming at us at once.

CHAIR ROWLAND: Julie, you're essentially saying

that the kind of guidance now for how you enroll people and find people and boost your enrollment and participation goes just so far; that you need the same kind of guidance about how to structure the delivery system on the end after you enroll them?

DR. HUDMAN: Absolutely. And it's hard. And there's Medicaid directors and folks around the table and I'd be interested to hear their experience. And we have a health reform implementation committee and everybody had their issue that they wanted to do: long-term care, dual -- you know, all the different issues that are important and we got so frustrated -

CHAIR ROWLAND: All the ones on our agenda.

DR. HUDMAN: All on your agenda, all very important. We created a delivery health system reform subcommittee and everyone's like, that's too big, and I said, I can't have like 30 committees. Right? We're only so big. And so, but I think that that part is hard, too; is that, everybody has a certain -- everyone sees the vision differently, so I think the nice thing, at least about health reform, is there are certain goals that all the states are going towards at the same time.

And so, I think there is some ability to share experiences and share implementation roadmaps across the country because certain states have done a really good job. Like, I can talk to people about coverage and I can go to other states and they can talk to me about payment reform or things that they've done. So, some sort of way to share that information, like I said, in a way that's kind of more of an implementation kind of roadmap would be, I think, very useful.

COMMISSIONER CHECKETT: This is a question for Jenny, and really on the heels of the discussion about managed care. I was very struck by your comment that much of the data that is out there on the Medicaid program in general doesn't include this large number of people who are in capitated managed care program. I wonder what ideas, options, solutions there might be to address that.

DR. KENNEY: So I'd say there are two promising avenues. You'll be hearing from Cindy Mann tomorrow morning and CMS is redoubling its efforts, I think, to support states in bringing the encounter data into the MACS and ANSIS files so that they will be available not just for research, but for program management. So I think that's one very, very important line of questioning tomorrow morning, to know the time line for that and how optimistic CMS is that will have usable data for all states in any real time frame in terms of this Commission. That's the first thing.

And then I'd say, I think really important to also work to merge administrative data with existing household surveys because we do have very powerful National Household Survey data. There's going to be increasing attention and perhaps more resources for increasing the state sample sizes, and that's another line of questioning for another

day in terms of how adequate those survey data are to tell us what's going on at the state level.

But with the administrative data, we do know who's in managed care and we do know a lot about, from the enrollment files, what the circumstances are. That would be so powerful to have those two sources of information together.

COMMISSIONER MOORE: While we're on this data system, would both of you say a few more words about missing pieces and what we could be doing to develop a better information base to look at access if you were designing the world?

DR. HUDMAN: The exciting thing is our agency is the lead on - and why they're both HIE I don't know, but we're the lead on the Health Information Exchange and we're the lead on the Health Insurance Exchange, plus we have Medicaid in the middle. So I'm hoping this is a good thing because there's so much overlap. Right?

But as we talk more about the information exchange and we talk more about -- we have a thing called a patient data hub, which was the Medicaid transformation grant, as we start to get data actually on labs and on clinical findings and I actually can match that up with payment data and other things, that's really powerful. Some states already have it. We're just now getting there, and then once we actually have a fully developed HIE, that's an information exchange, it's going to be just super exciting and powerful to be able to tell these stories.

Like I said, I think we're unique. Most states, it's not all kind of in the same place, and I think it's interesting because some states are worried about sharing it across their government or sharing it with the private sector. So that's one place, since it's all in one place, I think we'll be able to kind of hopefully have some synergy from those different sources.

But I do think there's a lot of promise. And one of the issues, as we talk about data, should be, how does the Health Information Exchange, how does HIT and some of the EMRs and things in doctors' offices and all the incentives that are in the Medicaid program to do that, how can that give us the information that we need on some of these access and process issues.

DR. KENNEY: And I would just add that I think it's important to address shortcomings in both Household Survey data and administrative data because they really do cover different parts of the access landscape. And I think we need to look at, in terms of the Household Survey data, the capacity to produce data estimates, to look at key subgroups, but also whether we think we're even asking about the right types - we are actually collecting the right types of information that tell us about access in a meaningful way.

In terms of the administrative data, I think places like the District that seem to be far ahead of some

of the other states could really lead the way in sharing off-the-shelf types of solutions to bringing administrative data up to standard, and I think the vision would be that there would be developed a set of measures with the administrative data that would speak to access and quality issues, and that states wouldn't have to keep reinventing the wheel, that there would be something that would be much more standardized that states could use if they wanted to.

CHAIR ROWLAND: Isn't this is an area where we have to weigh the burden on the states? Obviously administrative data is most accurate when it's used by the states and it's also less burdensome if it's something that you need to use in your process. So as we look at the balance between what you can get from administrative data and what you need for research purposes, we need to weigh those carefully, don't we?

DR. HUDMAN: And I was just going to comment on the administrative piece. There's only about five or six vendors that run the MMIS programs. And so, many of us have asked why there can't be more of a federal solution to that or an RFP or a set of standards, and there are some new standards in the Health Care Reform bill, but there's got to be -- you don't want to burden the states, but at the same time, there's only so many of these systems out there. They have different little bells and whistles, but fundamentally, they're the same.

And so, that's a place where we could partner with the few companies that actually are in all of the states and somehow get a collective, folks coming together and be able to figure out how to use the data a little bit better.

VICE CHAIR SUNDWALL: I'd like to follow up on that just a minute. You hit on a very important point. We're in the process of getting a new MMIS system. The only way we can possibly afford it is a coalition of states. The vendors have taken us to the cleaners for years, over and over, costly systems that then somehow don't fill the bill and it's really tiresome. I don't know if a federal solution is the answer there, but it really is a very costly thing we have to do and we'll not have the data we need unless we get it.

I'd like to just make one comment to Genevieve. Is it Genevieve?

DR. KENNEY: Jenny.

VICE CHAIR SUNDWALL: I like Genevieve. Your presentation is interesting, but I heard more about what we don't know than what we know. When you do health services research, I guess you identify the gaps, and it worries me that we're going to get paralyzed by identifying so much more research that needs to be done that we'll need to wait until we get some more studies before we can report.

For example, I'm not being critical of what you're saying, you're probably right, but the report you just published in the Urban Institute's study on where the children enrolled in CHIP was frustrating to me because your

data was dated. It was 2008 and we looked terrible in the State of Utah, but in fact, have a 14 percent increase in enrollment. So something the Commission -- since it was published.

Since what we have to be careful of is that we're not endorsing information or studies that aren't really going to be reliable for Congress to make conclusions on, I guess is the timeliness of it and maybe that's a perennial problem in health services research. It's something we really need to pay attention to.

DR. KENNEY: No, I think you've identified such a frustration for folks who are in the real world wanting to make realtime decisions. But 2008, by research standards, is actually pretty good, but it's not in a time of dynamic change, and I know Medicaid enrollment has been taking off around the country.

But I will say, because I had such a short amount of time I couldn't tell you everything we do know about Medicaid CHIP, I think there's a lot of low-hanging fruit for the Commission to tap into to put together, taking from different data sources that already exist, investments that have already been made, and pull together what would be a start at a picture of access that could be the basis for building and tracking over time. I think it will be incomplete, but I think it will be a good start.

COMMISSIONER HENNING: Coming at it from a perspective of women's health care, I know a lot of OB/GYN providers, nurse midwives and OB/GYNs, will take Medicaid for pregnancy, but can't provide just annual GYN care at the Medicaid payment rates. What I do, because I work for a community health center so we get reimbursed differently, when I see a woman for an annual GYN, I also do a lot of laboratory work. I check her lipid levels, I talk to her about heart disease, I talk to her about diet, and do a lot of teaching that I think is a very important part of just an annual checkup because most women treat their OB/GYN visit as their only visit, especially if they're poor. That may be the only time they're seen by a health care provider all year.

And so, I guess my question is, in this health care reform thing, are OB/GYN, certified nurse midwives, women's health care nurse practitioners, are they considered primary care providers when it comes to increased reimbursement rates?

DR. HUDMAN: Yes. The primary and specialists are increases, my understanding. I don't know. That would be my understanding and I think you hit the nail on the head with community health centers and why we pay them the way we do. We pay them kind of a bundled rate because it's an encompassing rate because we know that they do more things than just a basic exam.

And what I mentioned before, the opportunity in the Health Care Reform legislation is what's called a Health Home. And really what that does is allow a state, through a

pretty simple regulatory process, be able to receive 90-10 matching for what's called case management and other wrap-around services.

So some of the things, maybe not the labs and things that you're talking about, but maybe some of the education and other issues that you bring up in that kind of visit are things that actually then can be reimbursed at a much higher rate.

Now, as a community health center, it will be different, but I think that that's a really promising piece of the legislation that's there that can also be used.

CHAIR ROWLAND: But, Denise, one of the things that we'll want to look at is that that requirement in the legislation for the increase in primary care payment rates does specify physicians in the March update and we have to see how broad that will be.

DR. HUDMAN: Don't they usually -- I mean, my understanding is we do primary and specialists at how we pay, but my understanding is usually OB/GYNs are considered primary care providers.

CHAIR ROWLAND: But I'm not sure that nurse midwives would be.

DR. HUDMAN: Oh, that might be.

CHAIR ROWLAND: That would be extended. I think it goes to the physician, but that's obviously one of the issues we should look at as we look at the provider fee issue. But Sharon had a point.

COMMISSIONER CARTE: Jenny, in your access slides, I noticed you had the ED rates and that's something -- I don't know if you're prepared to delve into that today, but I'd be interested in looking at that further by state. Is there a bimodal distribution there where you have higher rates concentrated in a few states? Do rural states have a different experience or challenge? And lastly, could we look at some of the states that have successfully tackled that and been able to lower a high utilization rate that would serve as models?

DR. KENNEY: I would just say those are great questions and the research literature on emergency room use is really mostly at the national level. There are a couple of local studies, but I don't think we know how, for Medicaid or CHIP enrollees, that varies across the country except for some very limited studies.

COMMISSIONER CARTE: I'd just like to say, I think that this is an important question. I know you're aware that that's one of the pediatric measures now that states' Medicaid and CHIP programs will be asked to look at.

COMMISSIONER MOORE: Judy, I think we will hear some more about some of these subjects tomorrow, as someone mentioned, from Cindy, but it sounds to me, from what you said, Jenny, that you do feel that the staff could put together for us an outline of some measures and things that already exist so that we could have a template or a beginning, and then maybe you could also put together the

list of holes that need to be filled.

My concern would be when you're doing that on staff, that you also look at some of these underlying systems issues and the potential for more standardization and less expense for the states and more efficiency in the overall process of information development and data availability.

CHAIR ROWLAND: I think it's also important, as the ED rates are looked at, there's new research that was just out in Health Affairs this last week that shows greater use of ED across the insurance categories. So I think we need to look at not only the Medicaid utilization, but how that interacts with how other providers of payment are handling ED use. Andy?

COMMISSIONER COHEN: Actually my comment builds off of Judy's. That was sort of the first half of mine. But I wanted to throw one of your questions and your sort of teaser about what is available back at you, Jenny.

You said that there are some data available to help us get a better picture of what access is like and you asked us the question, which I want to throw back at you, whether we need to sort of look at data that looks at things from a national state or a sort of smaller level. Obviously, access on the ground is an interaction of a whole bunch of factors, some affected by federal action, some state, and some just sort of like what your health care infrastructure is in a very given geographic location.

I'm just wondering whether we have anything, if any of the low-hanging fruit that we have available could get us to a place where we could have any sense of what the actual variation or sort of what problem areas might be on the ground in the local area.

DR. KENNEY: So certainly there are opportunities for better understanding local variation with the administrative data, and there's some studies of particular states that have raised really interesting and provocative issues around that.

But we're really limited in what we can do there. If we want to look at kids, so many are in capitated managed care plans in Medicaid and CHIP, and so they're just not represented in the data. The household surveys, we have more potential for looking at children because every four years, the National Center for Health Statistics has been doing a survey of children and it does have the capacity for many states to provide Medicaid and CHIP level data.

But we haven't used the data with that in mind yet, so we don't know how robust it is and how well the surveys are doing at representing the experience of those kids, but it's absolutely low-hanging fruit. It's already collected. We have two years of data available and it certainly could be pushed.

The National Health Interview survey, long-standing, annual survey which is going to be getting an increased sample in the coming years leading up to health

reform, which will provide potential for the larger states of doing some tracking at the state level.

But I think your question back to me is how important is knowing what's going on at the state level. I think it's critical. You've seen one Medicaid or CHIP program, you've seen one. We all know how much variability there is, but you have to go beneath that. So just knowing what the average is for the state isn't going to be sufficient either because we know rural versus urban. We know within a metropolitan area that there can be very different access problems.

So how that's achieved in terms of the kind of qualitative and quantitative data, mix of household survey that's already collected maybe some new survey efforts, administrative data, and case studies, I think it's going to have to be a picture that's put together that relies on many different data sources. But I think for the Commission to know what's going on, there's going to have to be an effort made to really work on all those three levels.

DR. HUDMAN: Can I just add, Diane? One of MACPAC's charges is the early warning system, and just to play the other side of the data issue on a qualitative aspect, I think that you could do something with the early warning system that divides states or metropolitan areas or rural areas, however you want to do that, under different factors of how much coverage do they have to expand, could be a factor, how strong the community health centers network is in a certain state or area, could be another factor, and you would want to divide it up that way.

Some of the things that we know from the data make a difference, or Medicaid typically uses. If they've expanded a lot for kids, but haven't for adults, or if they've done everybody at the same time, some of those factors are going to play out a lot, and I guess to me, I would think of the early warning system of maybe grouping states or areas kind of under those categories and having more of a qualitative way to look at it while we wait for the quantitative measures to catch up.

CHAIR ROWLAND: Well, thank you both and thank members of the Commission for this beginning discussion of where we go. It's obviously very much a beginning, but I think this has been helpful in setting out some of the issues we need to take on and the challenges. I want to thank you, Julie, and you, Jenny, for leading our presentations. Thank you.

Now we're going to take about a ten-minute break, so everybody please be prompt at returning, but we will give you a little break.

[Recess.]

VICE CHAIR SUNDWALL: If people could please reassemble. Thank you all very much. If the Commissioners could please reassemble, we'll get started with our next panel, which I think is a continuation of the panel we just had, because obviously access to care issues and provider

payment and participation issues are intertwined very close together. But we're very pleased to start this discussion with Peter Cunningham, a senior fellow at the Center for Studying Health System Change. He has been the director there of quantitative research who has long focused on physician participation, on issues of the safety net and access to care for low-income and vulnerable populations. And Andy Allison, the Executive Director of the Kansas Health Policy Authority, who has been both a Medicaid director as well as a Medicaid budget analyst here at OMB and a researcher as well. And they're going to really share with us some of the provider payment issues that MACPAC should focus on as part of our analytic agenda, help to get some of the key data and information out, as in our last panel I'm sure will identify many gaps in what we know and many options that we ought to be thinking about as we move forward to look at these issues.

So, Peter, let's set this in motion. Thanks.

DR. CUNNINGHAM: Thank you, Diane, and thanks to you and Lu for inviting me. I'm pleased to be here and to share our research with the Commission.

I guess probably the first thing that we need to remember about reimbursement rates in Medicaid is that it's unlike Medicare. With Medicare, you have the Federal Government setting rates that apply to physicians nationwide, with some variation due to the cost of medical care. In Medicaid, it is 50 state governments setting fees, so you have 50 different entities. You don't have a single entity that is setting fees for physicians.

Now, all the states use some kind of fixed fee schedule, but there's no standard methodology for setting fees. There's no real common framework or anything that they use. And so states have much more flexibility and autonomy in setting fees than other aspects of the Medicaid program, such as benefits and cost sharing and things like that. So states will often use fees, you know, tinker with fees to do things like increase access or control costs because they have some flexibility in doing so.

Over the history of the program, Medicaid fees have not kept pace with either Medicare or commercial fees, and I'll be showing some data on kind of where they currently stand. And, you know, again, it has kind of been an up and down issue in recent years with the fees, and in good times, when state government revenues are growing, increasing Medicaid fees is one of the main tools that states have used to try to increase access to physicians. However, in bad time, when revenues are shrinking, but Medicaid rolls are usually growing, the states turn to fee cuts to try to place some controls on their Medicaid spending. And we're seeing that right now, obviously, with our current recession, and states have the extra constraint of the maintenance of effort requirements in ARRA which prevents them from making any cuts in eligibility. And so many states, if not most or all states, have cut fees in

recent years in order to try to control the growth of spending in the program.

So just to kind of give you a little overview on kind of what Medicaid fees look like, the best source of data on this is from state surveys that are conducted by the Urban Institute. The latest one was in 2008, funded by the Kaiser Commission on Medicaid and the Uninsured. And they did a survey for all 50 states of 33 services, including primary care and a broad range of specialty services. This slide, I just show three of the most common or typical services, and, again, these are fees for physicians. They don't include facility fees for the hospitals.

When the Urban Institute researchers calculated across all fees -- or all services and all states, they found that Medicaid fees were on average about 72 percent of what Medicare pays. And they didn't compute what Medicaid fees were in relation to commercial insurance, but we know from the MedPAC Commission that Medicare pays about 80 percent of commercial. So if you kind of extrapolate the two, Medicaid pays probably roughly 50 to 60 percent of what commercial -- and, again, that's on average. There's going to be variation by type of service and across states. So that's kind of where it is.

Now, you'll notice that these refer to Medicaid fee-for-service rates, and so that's what was included in the Urban Institute survey. Obviously, there was some discussion about managed care, and we need to know more about that. That's a lot more difficult to get at in a survey because, you know, the way capitation works varies so much across states, and we haven't really had any data on that systematically for about 10 years. But I think there is a sense that the capitation rates that states pay are based on their fee-for-service rates. So, you know, there are some caveats when you talk about managed care -- capitation rates, but I think in terms of understanding what the variation across states is and the relation to Medicare and commercial, you know, that's probably comparable to fee for service, as much as we know. But that is a gap in the research and the data.

Now, this slide shows Medicaid fees as a percentage of Medicare, and, again, it shows the 72 percent. So on average, across all states, all services, Medicaid pays about 72 percent of Medicare. That varies obviously by type of service, so if we're talking just about primary care, it's about 66 percent, and for other services combined, it's about 73 percent.

You'll notice looking across the years that there has been an increase in Medicaid fees as a percentage of Medicare, from 62 percent in 1998 to 72 percent in 2008. And so Medicaid fees have been increasing between 1998 and 2008. Fees increased about 42 percent for all services and 60 percent for primary care services. And so obviously what this shows is that Medicaid fees have been increasing faster than Medicare fees. Of course, we know the story. Every

year in Congress they're hoping to just not cut fees 25 percent or whatever it is, and if they get a 1- or 2-percent increase they're happy. So Medicaid fees have actually been increasing at a much faster rate than Medicare in recent years.

This shows the variation in Medicaid fees across the 50 states. Tennessee there are no data for, so that's blank. It's white. But basically it's colored so that the darker colors indicate higher Medicaid fees as a percentage of Medicare; whereas, the lighter colors reflect lower fees. And, actually, 11 states as of 2008 had achieved parity or greater with Medicare rates; that is, they were paying 100 percent of Medicare or higher as of 2008.

You'll notice that a lot of those states are in the western part, in the plains and the mountain states. You'll also notice that in the South they do pretty well. They're not at parity, but they're getting pretty close to parity with Medicare.

And if you look at the largest states in terms of population -- states like New York, California, Texas, Florida -- Medicaid fees tend to be lower, and part of the reason for that is they have some of the largest Medicaid enrollment. And so if you're a state Medicaid director or you're the state legislature and you're faced with, well, if we raise fees to 100 percent, we're going to have an even bigger budget problem on our hands considering all the Medicaid folks we have; whereas, folks out in the western states have smaller Medicaid rolls, and so there may be more of a sense that they can afford that.

This map shows percent change in Medicaid fees between 2003 and 2008. Again, a lot of those western states have been increasing at a much faster rate than other places in the country and have been bumping up their rates to achieve near or greater parity than Medicare.

So that's a little bit of background about what we know about the Medicaid reimbursement issues. Now I'd like to turn to a discussion of physician participation, and the data I'll be using comes from the Health Tracking Physician Survey, which is a nationally representative survey of patient care physicians that is conducted by my employer, the Center for Studying Health System Change, and funded by the Robert Wood Johnson Foundation.

We include in the survey some basic measures that try to capture whether physicians' practices are open or closed to new patients. And this is commonly ascertained by a question on whether physicians are accepting all, most, some, or no new patients of a particular payer category. And so you can see by these findings that a smaller percentage of physicians are accepting all or most new Medicaid patients compared to either privately insured or Medicare, and that a much larger percentage of physicians are not accepting new Medicaid. Essentially, their practices are closed to new Medicaid patients compared to the other payers.

We also know that Medicaid is highly concentrated among a relatively small number of physicians in the sense that there's a lot of physicians, maybe three-fourths of physicians will take, you know, a handful of Medicaid patients and, you know, they'll close it to additional patients. And then there's kind of a small group of physicians, you know, maybe less than 25 percent, who take a lot of Medicaid patients, you know, to the extent that it comprises 25 percent or more of their practice revenue. So in terms of physicians providing Medicaid, it's a very highly concentrated group.

Then this slide just shows the variation in acceptance of new Medicaid patients by specialty area. And, you know, it's driven by not only differences in reimbursement for particular services and specialties, but also things like the demand for care. So, for example, pediatrics has high acceptance because so many kids are going to be covered by Medicaid, and it's difficult for a pediatrician to say that, you know, they're not going to take Medicaid. Also, the nature of the different practice settings can also influence whether different specialties accept Medicaid patients or not.

In the survey we also ask for physicians who say they are not accepting Medicaid patients. We also ask the reasons why they don't accept Medicaid patients. And probably not surprising, the most frequently cited reason, 84 percent, is because of the low Medicaid fees. But we also find that there's other reasons that physicians are also concerned about. Administrative burden is one. So there is often a lot of paperwork in terms of being -- you have to document that they're eligible, that they're qualified, and the types of services. Some of that is also mandated or they're attempting to control fraud. So paperwork is a frequently cited reason.

Delayed payment is a reason. In fact, other research that we have done shows that even in states that have high fees, if the payment is very close, that kind of negates or offsets the effects of high fees. Even if there are high fees, physicians don't want to take Medicaid because the payment is too slow. And I think Julie Hudman was talking about some moves towards more electronic payment, and a lot of states have moved to electronic payment in order to try to facilitate and speed up the payment issues. And I don't think we know a lot about how all of that is working and is it really reducing the speed of payment and facilitating physician participation.

Then clinical burden is also mentioned, and that refers not just to the fact that a lot of times the Medicaid enrollees are sicker or they have more difficult or challenging health problems. But I think physicians also frequently complain about, you know, lack of compliance among Medicaid patients. Some of that reflects the churning in and out of Medicaid. But if somebody shows up with diabetes and they give them a prescription or they tell them

to come back, frequently they don't comply with that. So there's some frustration sometimes that physicians will express about the problems that they have in trying to care for the Medicaid population.

Then other research that we've done has identified other factors, other characteristics of physicians and their practices that also are associated with higher physician participation. Younger physicians tend to accept Medicaid patients more than older physicians, and I don't know if that's really a cohort effect necessarily, but younger physicians starting out maybe are just less selective about the types of patients they see.

We also see that the practice characteristics and practice organization makes a big difference. Larger practices, employed physicians, are more likely to accept Medicaid patients, and some of that may have to do with, you know, if they're more organized and they have centralized billing, there's some economies of scale. So the paperwork and administrative burden hassles that they mention are less of a factor there.

International medical graduates are more likely. I think a very interesting finding is that physicians in rural areas are more likely to accept Medicaid patients, and that could reflect both, well, there's fewer patients there for them to choose from in rural areas, so they're basically going to take whoever shows up. But also I think physicians in rural areas know that there aren't really any other options for patients, and if they don't see a Medicaid patient, then that patient isn't going to have access to care.

I think the other thing is that when we try to look more directly at whether the state variation in Medicaid fees affects enrollee access, we don't see a lot of very strong effects. They are weak at best. So we don't see a lot of impact on emergency room use, physician visits, visits to other health providers, or even self-reported measures of access. And, again, the reason for that is, yes, fees are important, but there's a lot of other things that determine both, you know, the supply of physicians in a given area and whether those physicians accept Medicaid patients. And in some areas it is the case that low overall supply of physicians is going to be more of a problem than low fees. So that if you have a very low supply of primary care physicians or specialists, it doesn't really matter how high you raise fees; they just aren't around to see patients.

So I guess in conclusion, fees are important. You might call it a necessary but not sufficient condition in terms of increasing access. But I do think that in terms of physician participation in Medicaid, it does require a more comprehensive approach.

That concludes my talk. Thank you.

VICE CHAIR SUNDWALL: Thanks, Peter.

Andy?

DR. ALLISON: Thank you, Diane, and I very much appreciate the opportunity. It's certainly an honor for me to present, and I will be slow enough to allow Peter to find the presentation here.

Greetings from the heartland and from the National Association of Medicaid Directors. It's very nice to see the Commission right off the bat approaching Medicaid directors and the states to understand their issues. And you'll get a little bit of a whirlwind tour from me, and hopefully we have time for questions to follow your own interests.

I want to tell you a little about Kansas Medicaid so you understand some of the few ways in which we're different and then talk a little about how we approach program management, which I think addresses a few of the questions that the Commission has already addressed this afternoon, focusing on assessing payment for professional services. And then I'll try to draw some of my own conclusions about how that might have an impact on MACPAC.

The Kansas Health Policy Authority is one of two states whose Medicaid program is run by an independent agency. I report to a board who is appointed by a mix of political elected officials in Kansas. We operate the state employee health plan as well. We are charged with collecting, using, and disseminating health data, which we do quite a bit of. We develop health policy recommendations.

Our strategic priorities, just for your information, this year -- we set them in June at the strategic planning meeting -- were to address programmatic risks from repeated cutbacks to our administrative funding; implement federal health reforms and inform key state choices that relate to the Affordable Care Act; and to initiate payment reforms to improve and control public spending and support ongoing health system reform. That is a mouthful.

Kansas Medicaid, we have a fairly thin layer of coverage for adults, so we just cover up to -- it's about 30 percent of poverty. It's fixed by dollar amount, so it falls each year as a percent, at least when we have inflation in this country, and childless adults are not covered in the Medicaid program at all, so health reform will, of course, entail a large expansion.

CHIP was recently expanded by our legislature to what now amounts to 241 percent of poverty. We have premiums beginning at one and a half times poverty, which the legislature is now asking CMS to raise by the amount between where they are now and what the Affordable Act defines as affordable.

We have managed care organizations that cover -- and you'll see this in the next slide, Peter. For a little over half of our 330,000 recipients broken out by the populations that you see across the top there, we do not have any managed care for the complex, higher-cost

populations, just the income-related children and families, most of them -- we have part of the state with only one managed care organization, and choice is required. We have, of course, rolling enrollment. So about 180,000 who are in managed care organizations.

You can see along the right-hand column the agency that's responsible for each population or component of our program by service areas, so we have another agency responsible for mental health, behavioral services. We have then another agency that is responsible for long-term care, the nursing facilities and the frail elderly waiver. You can see the really large mix of programs that cover various populations across various agencies in Kansas. This I think is one of the more illustrative descriptions of our program.

Next is a slide that I share as often as I can. When we're trying to set priorities in the agency in running Medicaid, the first question is what's your biggest problem or cost right now in public life is the greatest issue, and so this chart explains just the growth in Medicaid. Now, when you choose a time series, start and end points matter. So it would differ if it was 2005 to 2010. But for this 5-year period, we're explaining something like \$400 million worth of growth and apportioning it. It's a decomposition for the mathematicians in here. There's not a cross term. I don't know how to deal with that. And so what you see is a relatively consistent story, that the disabled are explaining two-thirds of the growth in Medicaid, so you've seen the static view, which is that these populations explain most of the spending. Well, what about the growth? This is where the growth almost always is, except in the teeth of a recession, which we are currently in and which will change that picture when we take 2010 into account, and you'll see not negative growth attributed to families, but I'm sure very significant positive growth.

So how do we manage Medicaid? At least how do we hope that we're managing Medicaid? Our approach is to have the following goal: informed, disciplined management. We have adopted a device, comprehensive, written, data-driven evaluations. I sometimes refer to them as reviews. The idea is to improve cost-effectiveness, achieve savings, develop and apply policy goals, increase program integrity. We write this stuff down. We look at data. We post it online. We have 27 of these posted online. I don't know if you were given the one on physician professional services. That's a fairly good example of what we do.

This is how we intend to manage, so we have at least -- at full strength we have nurse -- staff who are nurses, who often are giving prior authorizations, et cetera. We literally ask them to help us write these. In fact, they were the primary author. They're responsible for looking at the data. In many cases it was the first time they had actually looked at their program in that comprehensive way.

So the intended benefits of this -- I cannot say

that they have all been achieved -- are to provide a standard by which public discussions can occur, policy decisions in each area are made. I would say in those two cases only about two or three of the 27 have really generated that kind of feedback from stakeholders and others, in particular, the very potent review that we wrote about pharmaceutical spending. A different story.

So we're trying to drive continuous program improvement. In other words, we expect these to be repeated. We expect to come back to the recommendations, see how we did, et cetera, support data-driven policy, et cetera. This should all be familiar to you if you've looked at MedPAC's website and are familiar with what they do. We, of course, were aware of MedPAC before we started. My good friend Mark Miller runs it. We're not MedPAC would be one of my conclusions today.

I'm just going to summarize findings from one of these program reviews, and that is, for professional services, we finished this very early this year. We called it 2009. The data is for fee for service only for 2005 to 2008. A couple of things happened during that period which make it difficult to interpret the data. One is that we increased physician rates -- did show up on the slides that Peter illustrated that we increased physician rates associated with money we were able to generate through a hospital tax. In 2006, at that time 86 percent of the Medicare non-facility rate, which in many cases turns out to be higher than the other, and expansion of MCO coverage, so we shifted 50,000 kids and moms out of fee for service into managed care in January of 2007. And so you're looking at the residual following that date. So a few of the findings.

Our provider enrollment in Medicaid held steady from 2005 to 2008. It's something around 160 percent of the number of physicians that are actually in the state. This is just a way of saying we overcounted. But when we did what Julie described earlier and actually looked at participation and used administrative data as our counting rule, we found also very steady participation across this time frame. The number of billing physicians in Medicaid was about 89 percent of the number of licensed physicians in Kansas. I write it that way because we do have a border city, Kansas City. So this is not a true percentage, I would say, for participation. Sixty-one percent of physician's assistants and 49 percent of advanced registered nurse practitioners.

No clearly measurable impact of provider rate increase on participation, just based purely on that aggregate result. Many anecdotal reports from physicians suggest that this was, in fact, very important in their participation, continuing participation, or others' participation in the program.

Just one other point that I would make here in this setting is that the ARNPs play a substantially larger role in Kansas than in the U.S. as a whole. So we have two

to three times a higher ratio of ARNPs in Kansas, both licensed and, roughly speaking, participating in the program than you see at the national level.

COMMISSIONER ROSENBAUM: What is an ARNP?

DR. ALLISON: Advance registered nurse practitioner. And they are paid in Kansas at three-quarters of the rate paid to physicians service by service. I would say just adding onto Peter's comment, we have a very high rate of electronic submission of claims in Kansas, so our MMIS system accepts Web-based submissions of claims, and so when you factor pharmacy claims in, we're way into the 90-percent range for electronic submission, and we pay very quickly.

So it's a longer list of limitations looking at this study of professional services than findings and results. The state's analysis of impact -- the impact of rate increases is obviously confounded by countervailing policy changes, so we increased the payment rate. We decreased the number of people who are served by fee for service. And I'm not sure how to tease those out. In fact, I think as a researcher I would say you've pretty much got to do this at the multi-state level over time in order to be able to identify the real effect.

The second issue, I think using Medicare as a benchmark for the payment rate may or may not be the best indication of access, and here's why. We have just implemented, after a four- or five-year process, a data warehouse that includes not only Medicaid but the state employee health plan, which uses all the major payers in the state, and we have real pricing data for all this. We're starting to publish it on our website, and so, Peter, this is right in line, I think, with what you were pointing to earlier. We just measured this and found that Medicaid pays at about 51 percent of private rates in Kansas, which if you do the math suggests an even larger differential between Medicare and private in Kansas than you mentioned earlier. Public-private payment ratios differ pretty dramatically by procedure.

Limited data. We have very limited data on the Kansas workforce. Our agency is actually charged with managing that data, and we've known that it was inadequate. It very much limits our ability to match physicians to their practice location, and in a rural state in particular -- I suppose this is true in urban areas as well -- a physician will practice in more than one setting over the course of a week or a month. And that may actually be a desired practice model for rural or frontier areas, so our inability to map individuals to their practice setting poses a -- really undermines our ability to measure access within the state region by region.

We don't yet have our encounter data built into this high-tech data warehouse. That is to occur in another two or three months. We're now in the third year of our MCO fourth year of our MCO contract and still have yet to

really get use out of the encounter data. And now we're trying to fit it into a new rubric, which is this data warehouse. You have to map it to something.

I would point to other evaluations. Just one of the other 26 includes -- which is a review of our MCO program, which we call HealthWave does reveal that we have access issues. We know we have access issues, and this is sort of more of the same from Julie's comments:

Long waits in doctor's offices for children. That is from CAHPS.

Limited access to specialists for adults. That's from CAHPS.

Relatively low ratings of providers for adults. Normally you hear that individuals by wide margins are happy with their own provider, and it's not quite as wide for adults in Medicaid in our state.

Low rates of diabetes care for adults, and that's actually from HEDIS measures.

So we're very pleased that with the new data warehouse we'll be able to extend analysis of HEDIS not just from our MCOs but into our fee-for-service program as well, and one of the key drivers is that direct comparison.

Another limitation would be a much broader point, and that's our ability to use the data we now have.

Administrative cutbacks. Just serial reductions in our staffing and administrative resource have left us with limited capacity to, number one, implement the recommendations we've already made; and, number two, to expand the analysis, which you will always do. You will never get to the bottom. That's what managing health care means.

What were those recommendations? We call them here State Action Steps so we can distinguish from recommendations from MACPAC or for MACPAC. We recommended to ourselves and our board adopted these: rebase Medicaid fees to a flat percentage of Medicare. We actually did this while we were working on the review. They varied from almost nothing to 800 percent of Medicare. And we realized that that's probably not a good starting point when your goal is payment reform to implement a medical home and to encourage care management, which always has to do with bundling, et cetera. You don't want to start that when you have such a wide variation, too many winners and losers. So we took the opportunity of needing a very small saver to actually level out.

That we have done. Implementing a medical we have not done. Collecting information on practice location and specialty we have a plan to do and have taken a fair amount of time to develop that but have not yet done. Documenting reasons for disenrollment, very important. That's an administrative process that we could engage in and have not.

Improving MCO provider surveys and extending them to fee for service. Why not ask physicians directly -- this is not hard today using Web-based processes. We actually

have made some progress as a result of the HITECH Act, creating the mechanism to do that. And just as anecdote, we sent that survey to far too many providers because we could not map their practice to the individual. So we would send a questionnaire that only needed to go to one person to all of them and ask them a bunch of questions they couldn't possibly answer. So we're hoping that that is a catalyst for us to actually get to this last action step.

So possible implications for MACPAC, of course, it will take you many meetings and I'm sure months to begin to draw these conclusions, and I hope you've learned something from Kansas' experience. Here's what I would suggest as takeaways.

For states like us -- and not all states are like us -- improving management of provider payment and access will require: new data, better information management systems. I think you have to have that at the state level. You know, I understand that we need data aggregated sometimes in order to even do the research and learn about the Medicaid program, one example this afternoon. But I also think you need that at the state level because, number one, you won't know if you have good data unless it's first and foremost managed there.

Number two, we need new contracts with MCOs. Sara asked this question earlier, and I couldn't agree more. Our MCO does not have the teeth in it that we need to hold our MCOs to account. We know that.

Leading to the next challenge, we need experience and capacity at the state and federal level to do numbers one and two.

We came to the conclusion in Kansas this year that we really did not have this and have completely reorganized -- sorry for whatever advice I gave Julie two years ago -- and are right now looking for new expertise to come in who can actually understand the contract and understand the data that we now have in volumes.

I guess here's the example. You're flying a plane. We can now see out of the front window. We can. We really are looking at the data and have far more of it that we can understand. We just don't have a flight plan. And to be honest, we don't have enough pilots. And so the question, I guess, for MACPAC is: What can you help with? Not all of this is something I think MACPAC is naturally built to do. We need to identify best practices and to distinguish experiment from established reform.

My legislature and policymakers, my board, ask routinely: What can we do to manage what we know is the number one issue in Medicaid? And that is the high needs, chronic, often multiple indication, high needs populations, SSI disabled, for example.

What's the answer to that question? Is it capitation? Is it a medical home? Something in between? ACOs? Very difficult in Kansas. We don't have -- in practice associations, a lot of onesie, twosie docs. It's

not easy to answer this question, what's been documented and what's just an experiment that sounds good from another state.

Provider access and participation depend on other things besides rates, and both Peter and Jenny have -- and Julie -- all described this. Here are some examples. Medicare medical education incentives. So we don't have enough providers in Kansas, and I would point to Medicare payment policy first as having the most impact on how many physicians we can train in Kansas.

Number two, state provider training and scope of practice laws so that the state contributes to provider education as well and defines what those providers can do and what then Medicaid can pay for upon graduation and entry into practice. That's an extremely powerful tool, and you always have to recognize that medical markets are local, and there are some limits to what federal policy can do, so carefully considering that appropriate federal role.

I would reemphasize what you've already heard, the hassle factor. That's both a matter of administering the program. I would just echo the comment that there's really no reason to experiment with 50 different ways to pay a claim.

Number two, it's a function of where we're investing our administrative effort to control cost. Is it with auditors who are looking for program compliance? Or is it with managers who are looking to prevent the cost in the first place? I don't think there's anyone at any table, probably in any industry, who would say that you're going to get more bang for your buck after the fact than before. But that's, in fact, where we're investing our dollars, both federally and I would say at the state level.

That will conclude my comments.

CHAIR ROWLAND: Thank you. Thank you both.

Questions from the Commission?

COMMISSIONER HOYT: I had a question, for either of you, I guess. Care of moms and kids is so foundational to any Medicaid program. I'm just wondering what the research tells us about reimbursement for maternity services and pediatric care given that there's really no counterpart in Medicare.

DR. ALLISON: Go ahead.

DR. CUNNINGHAM: Well, I think primary care tends to be paid somewhat lower in general than for a lot of specialty care, but their rates have been increasing the fastest. And participation by pediatricians is pretty high in general. Of course, pediatricians are one of the lowest paid specialties, but I think with those types of providers that they almost -- I mean, it's -- their calculation about whether they should take Medicaid or forego Medicaid to try to get more commercial and higher payers, that's a tougher decision because there's just so many more of their patients that are going to be enrolled in Medicaid than, say, for adults, although obviously that could change now with health

reform.

So I think in general for moms and kids, I mean just kind of as a general statement in terms of access to primary care, I don't think that that's where the problem is in terms of access. Now, obviously, you can always find, well, there might be some states or some counties where there's a dearth of providers. But, you know, just kind of as a general statement, I think access to primary care is pretty good in Medicaid, if not very good, and it's really the access to specialists where there tends to be more of a problem, not just because of the provider reimbursement issues but sometimes that's where you see shortages of specialists in certain areas.

CHAIR ROWLAND: Robin.

COMMISSIONER SMITH: Hi. I'm a parent of a child who is very complicated, and so first I have a comment, then a question. We were part of a program that was all inclusive that was a partnership between Medicaid, the Department of Social Services, and the hospital. The hospital was the private entity. And it was very -- it had very good outcomes, both socially, emotionally, developmentally, and medically. So I know it can be done. And it also saved on average about \$10,000 a year per child, so I know it can be done effectively at less cost.

But my question is: You commented that you had switched a certain portion of mothers and children over to managed care programs. Did you get any disgruntled parents? Did they want to go to the managed care program? Did they want to stay fee for service? How did that work? And do they like it?

DR. ALLISON: That's a good question, and I actually have a review here. I'd have to look at the data to see if, for example, CAHPS, Consumer -- whatever it is; it's the consumer survey that asks questions like that and allows you to answer. I don't know if those changed much. We have received -- I'm not aware of feedback or complaints from consumers in that switch from fee for service to managed care. To them it would have been a little bit oblique because managed care was already an option statewide, and it just became mandatory. And the option, the choice for them changed from one managed care versus fee for service to just managed care for about 90 percent of our population. And those changes would have occurred upon entry into the program primarily.

So because of the turnover, et cetera, I'm not sure how common a circumstance it would be to be forcibly switched from, you know, one to the other. Very little feedback. I'm not really aware of complaints or negative --

COMMISSIONER SMITH: Were they able to keep basically their same physicians and care that they already had? Or did they have to switch when they switched into the managed care?

DR. ALLISON: It has been long enough -- we did have transition plans for those who were actually enrolled

in those two months before and after the switch. We did have transition plans to identify primary care and to try to make sure that they were able to maintain. There's a tremendous amount of overlap in the networks between our fee-for-service program and the two managed care programs. I couldn't possibly give you a numeric answer to that, though.

DR. CUNNINGHAM: In other work that we do, that is one of the main complaints that we hear about when people are transitioning into managed care. Either they choose a plan and they are not aware that their doctor is not in the plan, and so that creates some turmoil; or their doctor is not in any of the plans. So I think that is one of the issues that does come up frequently in the Medicaid managed care.

COMMISSIONER SMITH: Okay. Do they have to change -- do they have to opt in frequently? Or do you change it -- how do I say this? I believe in our state -- my son is special needs, so it doesn't affect us as much. It's an annual thing. You have to opt into a certain managed care program, and if you fail to do so they pick one for you. Is that --

DR. ALLISON: Right. That's true. And what we're in the midst of changing, working through with CMS, is a process at re-enrollment to try to maintain if you fail to make that choice so that you're not defaulted away from your current choice.

COMMISSIONER SMITH: Okay.

DR. CUNNINGHAM: And plans vary a lot in terms of how much they try to outreach to enrollees to give them information about the provider networks. Some do a lot better than others, but there's a lot of variation out there in how they try to do that.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: My question I think is for Peter, but it could well be that, Andrew, you have experience with this as well.

I'm always somewhat confused by the comparison studies, the Medicaid to Medicare and Medicaid to private. So, for example, in private insurance today where there are very high deductible plans, I never understand the comparison on fee structure because it seems to me other considerations are point-of-service co-pays, basically a lot of uncompensated care, default. And I'm wondering, in terms of collectibles -- and the reason I'm asking this question is because the work that we've done -- now, we look at health centers which are quite controlled in their payment rate. It's a different payment rate. But the striking thing from the health center data, putting aside that their Medicaid rate is preferred to begin with, is the phenomenal loss they take in the private market. They're getting paid in the private market at rates that are below 50 percent of their relative relationship to charges compared to Medicaid, which, again, is high for them because of the special rate-

setting quality. But the losses in private market compared to charges are so high because, of course, they can't -- especially in our world where we're comparing. We're thinking about low-income privately insured patients, and I was struck by -- was it your slide, Andrew, that showed the amount of premium bump that happens under the Affordable Care Act compared to CHIP today?

DR. ALLISON: Let me clarify. That was our own legislative initiative.

COMMISSIONER ROSENBAUM: Right, right.

DR. ALLISON: It's not clear what CMS will do in response to that request.

COMMISSIONER ROSENBAUM: No, absolutely. But the point is there's a lot of cost share burden, not to mention the premium burden. And so when we're thinking about this, I just want to be sure that we are fully understanding how big the Medicaid shortfall actually is, and in some situations actually Medicaid may be the best payer. And, you know, my concern is not that we should not advocate for much more equitable Medicaid payments, but that, going to the point that Andrew was making about the other issues you're now exploring on the access front, the scope-of-practice laws, education and training, other things like that, that the picture I think is sort of huge, you know, and I don't know what relative weight to give the Medicaid rate studies.

DR. CUNNINGHAM: Yes, well, I think that's a good point, and it's always difficult to compare. The reason why Urban Institute uses Medicare and not private is because it's really hard to get national data on private payer rates because of all the variation and lack of data to some extent.

I think there's also -- I mean, I think the other issue with a private payment is that these are negotiated rates that plans make with physicians, and so whether a negotiated rate is going to be high or low often depends on, well, who has the relative leverage in that market, and is this a very desirable practice that the health plan wants in their network in order to attract patients. And then it's how do they deal with the out-of-network charges. So, you know, it's a big mess to try to really make a good comparison with the private.

I guess in terms of the community health centers, of course, that's a different -- you know, that's kind of a different animal because they're getting the higher Medicaid, the cost base, and I suspect -- I don't know, maybe you know -- one of the reasons that they don't get a good private rate is because they don't really have the leverage with the plans to demand a higher rate.

COMMISSIONER ROSENBAUM: Yes. Now, interestingly, this gap appears even in places in the country where, when you look at health centers and their relative market penetration, they're actually sizable players in a private insurance market. They have enough paying customers coming

in so that it's not a marginal line of business for them. And this phenomenon is something that I've been told by private health professionals as well that oftentimes Medicaid, once you factor in the uncollectibles, Medicaid is, in fact, a much fairer payer and a faster payer in many circumstances.

And so I'm thinking it's an area that we're going to have to develop a lot because so much of the data are, you know, for obvious reasons just having to do with how hard it is to do research, very sketchy. And I think it's going to change a lot from market to market.

CHAIR ROWLAND: Donna, did you have a comment, or Andrea?

COMMISSIONER COHEN: Yes, I did. I guess two for Andy, one a clarification, and I think maybe Sara asked it, but on the premiums, that's your proposal or do you have a premium program in place now? And if so, what's your experience on payment, people actually paying the premium?

DR. ALLISON: We have good experience with families paying the premium. We have a policy, which actually Jenny and I helped write a paper together about, comparing the other states, that does not disenroll during the year for non-payment. We are actually trying to change that because we feel like that allows families to maybe accrue too much of a deficit before they'd re-enroll. We've had premiums since the program began, and it began in 1999, and there are now between \$20 and \$75 per family per month. And the proposal is to raise them to, I believe, that 5-percent threshold or whatever CMS defines as the new standard of affordability under the ACA. That's pending before CMS now.

COMMISSIONER COHEN: I see. Okay. And then one other question. I know we're running short on time, but you did mention -- and perhaps you may want to come back, but I was very intrigued when, Andy, I heard you saying, you know, what MACPAC can do to help state Medicaid agencies around best models of care for managing costs, and if there is a specific area, because there is a lot out there. You've got CHCS and different people working on this area. So if you're aware of a specific area, you know, I think we'd be interested in that.

DR. ALLISON: Let me just comment. The Center for Health Care Strategies is a tremendous asset to states in technical assistance, real-time management, I would say. I think the flip side of that, and potentially an area that MACPAC might be able to contribute, either through its own staff or by helping to sort of direct or guide research that others would do, is in that higher-level comparison that can determine retrospectively what has actually worked, what has not worked, et cetera.

COMMISSIONER COHEN: Thank you.

CHAIR ROWLAND: Well, thank you both very much for your wisdom and your comments, and we look forward to continuing to work with you.

Now we're going to switch to the issue of how Medicare -- we've talked a little bit about Medicare fees, but now we're going to have Mark Miller from MedPAC join us to talk much more specifically about the dual eligibles and the work that MedPAC has been engaged in that we as MACPAC will be collaborating and joining them in looking at as a set of serious issues.

Welcome, Mark and team.

DR. MILLER: Thanks a lot. I have with me Carol Carter and Christine Aguiar who have both been working on dual-eligible issues, which is what we're supposed to be to talk about today, right? And they also do post-acute care work and other work, but that's what they're here for today.

What I'm going to try and do, and try and do fairly quickly, is bring you up to speed on MedPAC's discussion of dual eligibles. The Commission hasn't reached a point where they've made recommendations in this area, but there has been some analysis that they've gone through and some discussion that they've had, and I'll try and bring you up to speed on that.

There's a June 2010 chapter, which I believe you have or it has been made available to you, but that's what I'm going to be working from, and we can make that available.

All right. So having said that, let me just -- I'm not going to explain to you --

CHAIR ROWLAND: Mark, in addition to, as you discuss what you've put together, the process you've used, since this is a new Commission that's just beginning these deliberations, if you can talk a little bit about how you've worked through your analysis, and then you get to recommendations, because we're trying to figure our flow as well.

DR. MILLER: Okay. I can certainly draw on past examples, because, right, we're not quite there yet. But either way, on dual eligibles, one thing that I would say is that over the arc of the last several years, the Commission has had this notion of trying to move Medicare payment policy and other policy, you know, away from sort of volume-driven, service-driven incentives, more towards coordination and quality. And so the issue of kind of coordination is a big issue for them and frequently comes up in discussing any given policy, the dual eligibles and how they are dealt in any given context.

And so, you know, obviously we wanted to look at the duals because they're a complex coordination issue to begin with in terms of populations, and I'm going to try and give you some flavor for that. They are very expensive even though they often represent smaller percentages of the population, as you can see up here, 16 percent of Medicare beneficiaries, about a quarter of the spending; 18 percent of Medicaid, about 50 percent of the spending.

And then, in addition to just the usual problems of trying to figure out how to coordinate care, you have two

programs that often collide with each other. And, again, I don't think I need to go through this in any particular detail with you. I think you know this well enough. But Medicare is generally the primary payer for dual eligibles, focuses on acute care, hospital, physician, drugs now that there's a drug plan; and on the Medicaid side, it tends to be more nursing facility, personal care, and cost sharing. Obviously, there's a range of services, but those tend to be the big block dollars here.

Okay. I mentioned quickly that there are conflicting incentives. There's all kinds of examples and discussion we could go through, but just to kind of highlight one for you to give you a sense of the kind of thing that we're talking about here, it might be in a nursing home's interest to transfer a patient back to the hospital. If they get a three-day stay, they qualified for -- can qualify for a Medicare skilled nursing facility benefit, and that may result in a higher payment for the nursing home, and there's some sense that sometimes churning occurs for this reason. There are other examples of how the programs kind of work at cross purposes, but that's a quick one that most people can understand right off.

So then what we were doing -- and, again, we're not up to recommendations but sort of how we approach the problem, and this is not atypical, I think, is the notion of sort of grinding through the data at some level of detail to try and get a sense of whether it points in directions, and I'll try and give you a flavor for that as I go through this. But then at the same time, go out into the -- or in sequence, go out into the field and talk to providers who are out in the field or managed care plans, depending whatever the issue is, but in this instance talking to state programs that are trying to manage the care in an integrated way for dual eligibles.

But starting off with the data, we constructed a file that's current -- what I'm going to work from here -- and, again, I'm not going to get real complicated here, one, because I can't and -- they can, but I can't. But also I just want to give you a set of impressions and try to sum up from that. But we constructed a Medicare-Medicaid file, 2005 -- we're currently working to update it -- and we started to look at the population characteristics, the dual-eligible population by diagnosis and by ADL limitations, as well as spending, with the notion of not just looking at overall spending but spending by certain types of services and how it implicates different spending for the programs Medicare or Medicaid.

And so, for example -- and, again, I don't think this audience is going to be particularly surprised by a lot of these results, but the dual-eligible population tends to be more minority, poorer health status, poorer overall, live in an institution or live alone, have more activities of daily limitations, have poorer health status, that type of thing. And, again, I think for this audience that's not a

particular surprise.

We go into this in a lot more detail in the chapter, but just to give you a sense here, you know, in the policy world you tend to talk about dual eligibles as sort of a monolithic population, and what we're trying to do here is try and figure out a little bit more detail here. And so, for example, this chart shows you 38 percent of them have one or no chronic conditions; whereas, 8 percent of them have five or more chronic conditions. And also something that's going to recur throughout this discussion, 22 percent of them have dementia, and you'll see some more of this in just a minute. Again, there's much more detail in the chapter and sort of trying to look at the conditions that describe this population, but a quick sense, it's actually -- you know, some of them actually don't have a number of chronic conditions, and then some of them obviously do.

A sense here looking at the difference for the dual eligibles by aged and disabled, again, you can look at a number of different dimensions, but just to highlight one here, you get a difference in the Medicare spend here, and from other data we have a sense that the difference here is that aged tends to use more hospital services, and that gets driven out of Medicare; disabled tends to be more nursing services, and that gets driven out of Medicaid; and you see those kinds of differences. Again, there's much more detail that we could do through here, but just to leave you with some impressions.

The next point here is nursing homes, and, again, I think for this audience this isn't going to be a particular surprise here, but just focus on the right-hand bar and the middle bar, pick any of the clusters that you want. In the middle bar, the person has no nursing home spending, and the right-hand bar, this is the top 20th percentile of nursing home spending. The basic takeaway here is that nursing home experience can drive a lot of spending. It can be the difference between \$50,000 in a given year for a beneficiary if they have a significant nursing home spending experience. So, you know, again, from a policy perspective this would be in our work an area where we would begin to try and focus on and think about.

Here, also this is the dementia thing again. You see the standard layout that you've probably seen in Medicare populations and maybe in private populations where the per capita costs of the population increase as the number of chronic conditions increases, and here we're talking about congestive heart failure, COPD, that type of thing. And you see that same pattern for the dual-eligible population, but we also highlighted here dementia, and you can just see the add-on costs across the entire range of chronic conditions that dementia brings to it, you know, in the neighborhood of \$10,000 per capita when you have dementia literally stacked on top of these other situations. And so from the Commission's point of view, this was another

area that they wondered about, could you think about targeting policies around population that has dementia.

Okay. On this one -- I skipped over something in my notes here. Sorry. On this one what we were trying to do -- and, again, there's more detail in the chapters, just trying to get a sense of average spending depending on the particular impairment group, and so we looked at populations without an impairment, which have below average spending, and then you look at things like mentally ill, it's about 70 percent above the average; two physical impairments, two ADLs, almost two times the average; and then, of course, dementia again at two times the average.

This is just to illustrate how different conditions can have an impact on the services that you use, and in turn, from previous slides you know that this has an impact on program spending. So, for example, in Alzheimer's patients, 45 percent of their spend is for nursing home; in contrast to heart failure patients, 27 percent of their spend is for hospital services. And that, of course, would mean that that Alzheimer's patient would have a much larger impact on the Medicaid side of the ledger, and the heart failure patient a larger impact on the Medicare side of the ledger.

Okay. Now I'm going to shift gears a little bit, and I don't have a lot more in terms of prepared comments. I hope I'm okay on time, or whatever we're doing here. So then I'll shift gears a little bit, so to try and answer your question about process, we take the Commissioners through this. They have this chapter. They can read through the chapter in detail. We did a little bit more detail in our presentation, and we were able to present in more detail. And so I think some of the takeaway in looking at the demographics, the impairment, the diagnoses, the different kinds of services were -- there was some sense of should we be thinking about targeting programs around nursing care, should we be targeting programs around dementia, that type of thing, sort of teased out of the data a bit. These were not hard and fast decisions. These are things where the Commissioners were saying maybe we ought to spend a little bit more time thinking about this, and there's probably other comments that I'm not recalling off the top of my head.

But the other aspect of our work was then to start focusing on, well, if you're trying to think about integrated care, back to the way beginning of the program where the Commission was trying to think about this notion of coordinated care and managing across an entire patient's experience or beneficiary's experience, you know, where is there experience to draw from for this population? And so there are a couple of places. There's a program in Medicare within the managed care program, which is the special needs program. These are managed care plans that can be involved in providing integrated care to dual eligibles. I want to be clear. I don't think all of them do. Some of them do.

And there are actually eight state programs which have either grown out of demonstrations in the past or built on top of their mandatory Medicaid managed care programs and have what we think are actually integrated programs that are designed to provide care to the dual-eligible population.

Enrollment is voluntary, and generally it has been low. There's about 120,000 duals enrolled in these programs, and at this point their actual impact, the research on it is relatively limited. They are, obviously, designed to keep people out of the emergency room, out of the hospital, out of the nursing home. And we're right now going into the field to talk to different elements of these programs to see what they're doing and how they're doing.

Another way to think about it is this is a provider-based program, so this is not so much of an -- it's not an insurer-based program but a provider-based program, and, again, all of you have heard this, Program or All Inclusive Care, the PACE program. And it is aimed at the nursing home certifiable. It is generally personal care and adult daycare with a multidisciplinary team, and, again, same objectives, to try and lower hospitalization and lower nursing home utilization. There is some evidence from evaluations here that they have had some success, but here, again, enrollment is fairly limited, about 18,000 enrollees.

Okay. And then from our discussions and from the literature, you know, one question is: Why doesn't this go on more? And why can't we get more traction? And why is enrollment so low? And there's a couple of things that we've drawn from this. And, again, for this audience some of this may be well known.

There's not a lot of experience, particularly at the state level, but actually a lot of experience generally managing these types of populations and populations that need long-term care. There's stakeholder resistance to going into these programs in some instances, and by that I mean both providers and from the beneficiary side. Enrollment is voluntary, and that tends to probably keep down enrollment levels.

There is also, I think, from the states' perspectives when they look -- and, again, I think there are people at the table who know this better than me, but states' perspectives, how much investment for how much payback. If the payback is through the nursing facility expenditures, do you see that in the short term? How much payback do you actually see to get into coordinated care? Although this could be a topic of conversation, you know, for you and us, which is what does it take to bring states to the table to begin to focus on this. And then as I mentioned at the head of the conversation, the notion that you have different programs administering the two sides of the house.

So we're at the end of this, so if this has been a bad experience, it's almost over.

[Laughter.]

DR. MILLER: Anyway, so what we're doing right now is we're out interviewing programs across a range of states trying to get a sense of what they're doing, what kinds of models work, that type of thing to bring back to the Commissioners, because they'll want to look at this data, they'll want to hear the experience, then they'll start saying, okay, within Medicare rules, are there policies that we can begin to develop to encourage some movement towards coordinated care?

With that, I'll stop here.

CHAIR ROWLAND: Thank you. It's never a bad experience with you, Mark.

Any questions for Mark and his team? Trish.

COMMISSIONER RILEY: This is great and fast. I just have a thought on the challenges piece because I think there's another challenge about shared savings, so there's disincentives for Medicaid programs. I'm familiar with some telehealth programs that are fascinating, that work with nursing homes to keep them -- nursing home residents from EDs and admissions for things like urinary tract infections and things that are easily treatable, but for whom there's no incentive for the Medicaid nursing home to invest in the telehealth. It's a cost they can't be reimbursed for even though it saves significantly both in patient care and the quality of patient care and avoided costs to Medicare for the ED or hospital admission. I think that shared savings piece is a very large component that needs to be added to the challenges.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Two questions. One, are there state-by-state Medicare data so that we could look at duals by state and look at the Medicare-Medicaid data that you showed but broken down that way?

DR. MILLER: Yes, I think there's probably a couple of issues that have to be thought out before -- you know, if you have two numbers and just put side by side. Actually, there was some conversation beforehand comparing private rates to public rates. But what about the fact that the benefit design is different? And some of that begins to rise here as well.

You know, from state to state you have different eligibility; you have different service packages; you have different wage input adjustments like how much prices are different and that type of thing. And if you think about this, if people start looking state-to-state comparisons -- and this issue has come up in Medicare, incidentally, of just looking at geographic variations in Medicare and how you do that in a fair way. I think there's a fair amount of adjusting that has to be thought through so that you're not looking at something and going, "Look at the expenditures here," and it's a high-cost state as opposed to -- you know.

So it's not no, but I think that the technical questions of going through and grinding that data out I think have to be visited fairly carefully. Otherwise, I

think you could be set off on paths that --

COMMISSIONER ROSENBAUM: Will be wrong.

The other question I have is whether there's -- I don't know what you'd call it, like time lapse data on duals. In other words, do we know anything about how they arrived at their dual status? For example, people with disabilities I assume include a lot of folks who were disabled for two years and finally acquired their Medicare coverage, people who are elderly -- I don't know how it happened, and I can't help but think that there's some of the answers to how we do a better job for the population also involves understanding how they came to have dual enrollment status, what the lead-up events were to their acquisition of dual status in terms of things that might have been done, so that by the time they reached dual status, care was more efficient.

DR. CARTER: We do know -- and I didn't show it in this data, and we haven't looked at it. But it is possible to know the reason and how the beneficiary originally enrolled into the program. Did they age into being a dual or, you know -- and we might even know when they became disabled. We have not put together a longitudinal file to look at the care services over a long period of time, but one could do that, yes.

DR. MILLER: But in that instance, when you're looking at that, before they became eligible, there would be a health care experience that we wouldn't be able to capture.

DR. CARTER: That's right.

DR. MILLER: So we'd always be encumbered that way. And I also heard your question almost more like -- the data you might be able to crank through and say I found -- you know, this is the point where they became dual eligible and why. But I almost heard your question as what were the events, either health events or the management of their care or their home situation, whatever, that led them in some ways to that point.

MS. AGUIAR: If I could just add, the question of -- we are looking at that in the context of the state SNP programs and the states that were interesting and also on PACE. And what we're trying to sort of tease out is, you know, at that point the plans in North Carolina, that Community Care Network, they have responsibility for these duals to some extent, and what are they doing in order to try to prevent the hospitalization stays and in order to prevent the nursing home institutionalization. You know, on that sort of level we're trying to dig in there to find out, you know, where do they intervene, how often, and what are the interventions.

COMMISSIONER ROSENBAUM: And my last question is: Have you seen anything about one tiny, very elusive group, which is children with end-stage renal disease who also require Medicaid? This is a group that people understand very little about, and they're very costly. And I don't

know if they've shown up in your work.

DR. MILLER: We have not specifically looked at that. I mean, I have another person who looks at ESRD. I can ask there. But for this, I'm pretty sure we don't.

MS. AGUIAR: I'm pretty certain the programs that we're interviewing do not have either large populations of them -- we have not been asking specifically about that population, but we have not heard anything specific to that population yet.

CHAIR ROWLAND: Let me ask, as we proceed in our analysis of the dual-eligible situation, would you recommend we look at the disability population differently than we look at the elderly population? Because, obviously, within Medicaid there are the disability individuals who are on Medicare as well, and then there's a much larger group of disability people on Medicaid. And we're trying to decide sort of as we go forward how to priority things. What would your recommendation be? Or look at it by institutional, cognitive? What cuts would you suggest would make the most sense?

DR. MILLER: Part of the reason that I'm, you know, at least not able to give you a crisp answer is I think even within the Commission, you know, there's still this sense of, like, well, I see some cuts and some patterns in the data, and I don't think we've really even stepped up to the point where we've said, okay, we're going to focus in here, and, you know, this population or this particular condition or people who make it to the nursing home and try and pull in, you know, a policy model, constructed or whatever from our experience.

So I don't know that I have real clear advice on that, but you guys seem to.

MS. AGUIAR: I would just say -- and then I'll let Carol say her thoughts about this. I think, you know, when we are interviewing a lot of the different programs, and as Mark was saying, we are doing the state -- sorry. We are looking at these state SNP programs. We're also looking at some PACE programs. And we've also done some less formal interviews with different types of Medicaid managed care programs. And, you know, when we do that, we really are very aware of the different types of populations of the disabled dual eligibles. We're looking at the physically disabled, the MRDD population, and I think, you know, as well as those that need a lot of behavioral health interventions, and sort of trying to ask the plans and the programs sort of how do you -- do you even tailor your benefits, your service, the intensity of case management to these programs? So that is something that we definitely are aware of.

I would say the population that we really haven't looked at is the disabled duals that are not -- the disabled that are not yet on Medicare, and, you know, there could be population -- the programs that are targeting both, the ones that are duals and the ones that aren't. So we would be

picking them up. But if there are programs that are really, you know, just for the Medicaid only, that's not something that we've looked at yet, so, you know, that may be something for you all to do research on.

CHAIR ROWLAND: Because, clearly, Sara's point, we know that some of the disability population on Medicaid is in the two-year waiting period before they get onto Medicare. So they're kind of future duals, but they're not yet there, and that would be another group to look at.

DR. CARTER: I guess I would look at your spending because most of the Medicaid dollars are in long-term care, and so sort of that. And I think that there's pretty mixed evidence about how home and community-based services trade off for long-term care and whether there are big savings there. And so I guess I would look at the use of long-term services and how Medicaid might be, you know, a really good value purchaser and if there are good models out there, to look at that balance, because it varies widely across states in terms of which states are really investing heavily in home and community-based services as opposed to institutionalized services, and you can probably learn something that way also.

COMMISSIONER CHAMBERS: Yes, I just wanted to add a compliment to MedPAC for -- your presentation really hits a lot of the issues. I think this is going to be a great thing of MedPAC and MACPAC working together because the Medicaid issues are so nuanced. For years I was so frustrated being at HCFA and CMS at the lack of attacking the problem of duals from the administration's viewpoint of the Medicare program and the Medicaid program within the administration not talking. But there are opportunities now, and particularly within the administration, with the new Office of Duals, and Melanie Bella really encouraged that the work that she's done over the last couple of years will be very helpful.

It's a tough issue. I'll give you the example in Orange County where I'm responsible for the Medicaid program. We have 65,000 duals that are mandatorily enrolled; 4,200 of them are nursing home residents. We've got a special needs plan that takes care of 11,000 of the 65,000. But when you just look at even the long-term care piece of it, we only probably have 50 of the 4,200 nursing home residents that are enrolled in the SNP program.

There's all kinds of issues, as we've tried to engage the nursing home industry in the county, to understand as to how we can bring together coordination of benefits, and that the high cost of the Medicare program, as you said in your slides, particularly with the issue about hospitalization from the nursing home side.

So I really look forward to the work that you're doing and the work we can do, because this is a very, very tough issue, but I think there's plans across the country in states that are doing jobs in this area that I think will be very helpful in informing the work that we're doing.

DR. MILLER: I know I am on the question of focus, and there's always sort of approaching it through the data, you know, different populations of spending, and then there's kind of almost the practical, which is if you go out in the field and you find actually a program that is focused on something, some population, some condition, and having an effect, the \$64,000 question is whether you can replicate that or set up an incentive structure that allows it, because sometimes these things can be fairly unique to the area or unique to an individual, that type of thing. But sometimes the solution gets driven by the fact that there's actually a model working someplace.

COMMISSIONER COHEN: This is maybe asking too much, but have you been able to make any observations about differences in Medicare spending for duals depending on the characteristics of Medicaid programs that they're in or the states that they're in, meaning Medicaid programs that have a high enrollment in home and community-based services for duals or Medicaid programs with higher eligibility levels or lower eligibility levels or anything like that? Can you make any observations about whether there's anything about characteristics of Medicaid programs that seem to affect Medicare spending?

DR. CARTER: We haven't looked at that. I think it's an interesting question. I know that there's work going on at CMS in the Office of Policy that's trying to look at sort of how successful are home and community-based waivers, that are trying to focus on hospitalizations and do they avert them, and I think that that work is in progress, and I think they have a contractor working on it. It is a great question, though. But we haven't looked at it.

COMMISSIONER HOYT: I was wondering if you have any data on the extent to which the duals are enrolled with managed care plans compared to the non-duals on the Medicare side. And then a follow-up would be any splits on some of the data or service grouping slides that you had, how that would split be managed care enrollment and non.

DR. CARTER: Well, this is spending from claims, so it excludes the managed care population because there's no service-specific information -- did you talk about that already? In the managed care plan, there are no claims that come through, so you don't know what services were actually purchased with that dollar. So we don't know that. And I think about 11 percent of duals are enrolled in some kind of managed care plan, and that's below the non-duals.

COMMISSIONER HOYT: What's the percent for non-duals? Like twice that? More?

DR. CARTER: It's in the high teens, right?

DR. MILLER: [Off microphone] For the Medicare program generally, it's at almost 25.

DR. CARTER: Oh, is it that high? Okay.

DR. MILLER: If you're just talking about the MA portion of Medicare, it is, I think, like 22, 25 percent, somewhere in there.

CHAIR ROWLAND: [Off microphone] That includes the duals.

DR. MILLER: Yes, that's right.

COMMISSIONER CHECKETT: I would be interested in knowing if you have sorted out also the individuals with mental disability or behavioral health issues, if you've looked at your dual-eligible data and if you see any particular significant differences or things that might direct us in a certain policy direction.

DR. CARTER: There are some -- we had almost too much data to include in a chapter, so on the website there are four or five tables that look at spending by the chronic conditions warehouse flags, and so there are two or three psychiatric diagnoses in there.

I would caution you that our understanding is that psychiatric diagnoses in general are underreported, and those conditions were set up using Medicare data. And if you were going to flag prominent conditions in the Medicaid population, you might have different diagnoses as flags. And so there are things like psychosis, I'm not sure that that's a flag even though it's a common diagnosis in the Medicaid population. So there is a little bit -- we've done a little bit of work, and you can see the spending patterns. We didn't focus on that. But, again, I think to do a good job of that, I'm not sure that -- the coding is underreported, and the buckets aren't there really in a way that you might want.

COMMISSIONER HOYT: The source is still twitching just a little bit. Don't you risk-adjust your payments to managed care organizations?

DR. MILLER: In the Medicare program?

COMMISSIONER HOYT: Yes.

DR. MILLER: Yes, using HCC as the --

COMMISSIONER HOYT: So I'm curious about what the -- any generalizations you could make about the risk factor adjustment for duals versus non-duals.

DR. MILLER: Could you just give me one more sentence or two?

COMMISSIONER HOYT: I'm assuming you risk-adjust the payments for dual eligibles.

DR. MILLER: In this presentation?

COMMISSIONER HOYT: Yes. Well, not necessarily in this presentation.

DR. MILLER: Oh, I see. Okay.

COMMISSIONER HOYT: In general. You risk-adjust your payments --

DR. MILLER: Yes, when it goes to --

COMMISSIONER HOYT: -- to managed care organizations, so I'm curious --

DR. MILLER: Yes. Now I'm with you.

COMMISSIONER HOYT: I'm trying to get at what does the risk look like then in the duals who are enrolled in managed care plans compared to just Medicare enrollees who are not dually eligible but in managed care plans.

DR. MILLER: We definitely can know that. I can't speak to it right this second. But, yes, I mean, we have the risk scores for enrollees in managed care plans. My sense would be that you would find that the risk scores are higher, that they have more chronic conditions and they tend to have higher risk scores. That would be my guess.

DR. CARTER: Right, and there is a separate adjuster for dual eligibility, so not only would you have multiple conditions that would raise your risk score, but on top of that -- there is a dual adjuster on top of that.

I know that -- I think in the spring CMS revised its HCC methodology to start to cap -- do a better job of capturing some of the mental illnesses. Things like serious depression and psychosis I think were not in HCC and now are. And they understand -- my understanding is that that model will be doing a better job. I don't think there were big problems with it before, but I think that it will more accurately reflect psychiatric diagnosis now. That model I think came out this spring.

DR. MILLER: And I also think there's an adjustment for institutional status as well.

DR. CARTER: Yes, there is. That's right.

DR. MILLER: Which would also boost it for a lot of this population.

DR. CARTER: Right.

COMMISSIONER COHEN: This question is a little less about duals and more about the black hole that seems to be managed care, both in the data coming out of managed care in both Medicare and Medicaid. And I don't want to put anybody on the hot seat, but I'm just curious. Have you sought the data? Do you feel like you could get it as a Commission? Do you need Congress to say that it needs to be collected? What are the barriers here? And why has it been such a black hole for so long?

DR. MILLER: So there's probably some history here, just to back up, through. There was an attempt, and I'm blanking of how many years ago -- I'm just going to say within the last eight or ten years -- that they were going to collect counter encounter data from the managed care plans, Medicare managed care plans, hospital outpatient physician, and there may have been some other stuff in there. And that process

COMMISSIONER COHEN: When you say they, CMS.

DR. MILLER: CMS. I'm sorry. I'm sorry, yes. CMS. That process was stopped and at least at the time, there were some plans who said that it was very difficult for them to comply with the request. Some argued they, in fact, didn't have claims data. There was also burden issues and that type of thing.

There is now another mandate to collect the data, and some of the sense in the last several years is that a lot of managed care plans have moved more towards having claims data because they often run a PPO or something other than a closed model plan, so you would think you have to

have claims data to do that.

So I think there's some sense that it's more readily available, and there is supposed to be a collection episode -- effort underway. I'm under the impression that CMS is supposed to put out the guidance to collecting that data this year, is what I think. I want to say 2010. But I'd have to check that. But it is soon the guidance will come out, but if all that falls into place and all the rest of it, I still don't think you would see workable data for a couple of years. The first round collections are often problematic.

To your point about could we get it, we could only get it if a managed care plan agreed to give it to us. And so, you always have the issue of like if you get it from one managed care plan, what do you have, and that kind of thing and how far can you roam with it. You can test some questions, perhaps using that data, but if you're in a kind of national environment, it gets a little complicated.

The other reason that it's probably important to have it is probably not just -- I think there are several reasons. One is you may want to think about revising risk adjustment within the managed care world based on that data. That's one thought. Another thought is what can this fee-for-service learn from this.

So if managed care plans tend to have less post-acute care services, how do they do that? Is the quality any different and could fee-for-service learn from that? Those types of questions. I think the Commission has been pretty vocal on this, but this has been something that's been tried for a while.

COMMISSIONER HENNING: I guess my question, looking at things from a provider perspective, would be, are there things that we could be doing as far as preventative and health maintenance things that could prevent people from becoming dual eligibles? I think that's where your cost savings would be, or at least your biggest cost savings. So are there efforts underway to look at things that could prevent heart attacks, prevent the elderly from falling and breaking a hip and ending up in a nursing home, that kind of thing?

DR. MILLER: I mean, the only answer I can give you on that is that there are attempts that MedPAC has made in terms of recommendations to change the payment systems and other parts of the environment to try and encourage providers to have their payments, actually reward the notion of keeping a person out of an emergency room, keeping a person out of the hospital, that type of thing.

Now, those tend to be more focused to having a good platform of kind of primary care in the community that prevents, in the Medicaid population, the high cost events: ER, hospitalization, re-hospitalization, that type of thing, and decidedly some attempts to try and get providers to organize and try and stay focused on this, on that, so that their payment isn't driven by another re-admission, that's

more payment. Their payment is driven by, I will actually get a higher payment if I avoid re-admissions. And there are various ideas we could talk through on that.

But there is decidedly less focus in the Commission and in the Medicare world on the nursing facility side of things, which for this population is a large block of the dollars. And there, I think a lot of the efforts are trying to keep the patient out of the nursing home, in a home setting or some kind of setting like that, or an adult daycare center where they don't have to actually go into the more intensive nursing facility setting.

But most of the work that we've done is really more this notion of ER admission, re-admission, that type of thing. And I think what we're trying to start thinking about with this work is, and if we're going to think about the dual eligible population, that's going to very much bring us to the nursing facility side of things and how to think about that.

MS. AGUIAR: I would just add that those are the exact questions that we are asking when we talk with either both the insurance-based integrated care programs as well as the provider-based ones, sort of trying to understand who's responsible for that care coordination, that care management, how is it financed, and what are sort of the specific interventions. So that is something that we are currently in the process of looking into.

COMMISSIONER HOYT: If I haven't exceeded my quota yet, did you say which subgroups you're targeting inside the duals for potential savings? I forgot to write it down.

DR. MILLER: All I told you was, I tried to give you a flavor for the Commissioners' reactions. The definitely seem interested in dementia. The nursing facility stuff is pretty obvious. Those were at least two take-aways. And I want to be clear. There may have been more comments that I'm not remembering offhand, but those were two that I was [off microphone].

I also thought that there was some discussion of multiple chronic conditions, like there was also discussion of high cost beneficiaries and could you sort of target people either after they've had a high-cost event and then try and put them into a case management type of operation, or pick it on the basis of multiple chronic conditions. All right. This person is likely to be high cost, and so that person is going to be taken into some other kind of arrangement. Those were the ones that I took away.

VICE CHAIR SUNDWALL: I will apologize in advance for this question because I may have been distracted and you already answered it, but did I hear you say that CMS is studying the effectiveness of these home- and community-based waivers?

DR. CARTER: You heard me say that, yes.

VICE CHAIR SUNDWALL: Oh, good, good. Well, I heard someone. That's great.

DR. CARTER: Yeah, I think they have a contractor

looking at that and, if you want, I can send you information about that. I don't remember exactly who won. It was out for bid and I don't remember which contractor won it.

VICE CHAIR SUNDWALL: Yeah, because we certainly have them in Utah and we have a lot of faith that they work. I'd really like to see better data. I mean, we do our own, but it's just a gospel. You save money if you keep them in a hospital, and some of these nursing homes without walls, I wonder. But anyhow, I'd be interested in that.

CHAIR ROWLAND: This is clearly an area where this Commission and MedPAC will need to work together and to look at both sides of the coin, both the Medicaid side and the Medicare side, and the duals bring us together to do that. So I want to thank Mark and the team for being here today. We know we'll be seeing a lot more of you in the future, but thank you for today.

And at this portion of our meeting, we turn to the public comment where we let those in our audience come forward to give us their comments. Some have signed up, and if Paul Cotton is in the audience, we'll start with him as the first to the mic.

MR. COTTON: Thank you very much for the opportunity to speak. First of all, congratulations for getting MACPAC up and running to you and your staff. This has been long overdue and it's really good to see you get started on such a good note.

CHAIR ROWLAND: Please identify your organization.

MR. COTTON: Sure. My name is Paul Cotton. I'm with the National Committee for Quality Assurance. The reason I came here is to point out that there's actually a great deal of overlap between your mission and our mission, which is to improve the quality of care. Improving quality is often a very proven and effective way to reduce costs as well.

You're all probably very familiar with our HEDIS measures and the Medicaid Plan Accreditation that we just recently updated, which many states either require or recognize, but there are some other things that we've been doing recently that may also be of great interest to you. So I just wanted to very briefly run through a few of these.

One is a multi-cultural health care distinction program which recognizes plans for their efforts to provide culturally and linguistically appropriate services. This is very new. We just started doing it this summer and that's very important for helping to get at disparities in care. We have a primary care medical home recognition program which is a roadmap for telling health care providers how they can become a medical home and provide more effective care which improves quality and reduces costs. It's been documented.

We are developing CHIPRA measures of quality of care for children's health. We have SNP measures for the SNP plans that have been discussed here so much. We also have a new relative resource use measure which gets at some

of the inappropriate services and waste which should help produce savings in the long run as well. And we are now very actively working to develop some criteria for Accountable Care Organizations which hold great promise for improving quality and reducing costs. We'd be happy to provide you with further information on all of these things and look forward to working with you.

CHAIR ROWLAND: Great. Thank you very much.

The next Paul, Paul Kidwell from CMS. Is he here? No. Okay. Kate Kirchgraber from CMS? No. Michealle Carpenter from Families USA?

MS. CARPENTER: I have two quick questions. As you probably know, in the Affordable Care Act, was the new Office of the Duals was created and I'm wondering how closely you intend to work with that office as well as with MedPAC in focusing on the dual eligible population? And someone had asked previously whether there's state-based Medicaid information on duals? I know that the Office of the Duals is currently contracting to have state profiles on duals to come out some time later next year.

So first question is, what interaction do you see between you and that office? And then the second question is, what work or the extent of work would you anticipate doing, if any, related to the Medicare savings programs, which are Medicaid-administered programs that provide cost-sharing assistance for the Medicare population, the dual eligible population in terms of systems problems that are happening at the state level and how to improve that?

CHAIR ROWLAND: Well, we certainly will be coordinating not only with MedPAC, but also with the Office of Duals, as the statute tells us that that is part of our charge, and we will obey the law. And secondly, I think that as we put together our agenda and as we establish our priorities, we need to look at -- we can't in our first year do all things, so we need to be responsive to the requirements that Congress has given us to look at, the access and payment issues, and clearly the duals are on that list. But to the extent that we get into Medicare savings programs and their implications for Medicaid may be down the road, but that's part of what the Commission is going to be working through in the next months of how we will proceed and what issues we'll take on.

MS. CARPENTER: Okay.

CHAIR ROWLAND: Are there any other comments that anyone would like to come to the mic and offer? If not, I would like to thank you for being here and joining the Commission today. I'd like to thank all of our presenters who have really helped to set the stage, and especially to thank my Commission members.

So we are adjourned for today and we'll resume tomorrow morning at 9:00. Thank you very much.

[Whereupon, at 4:30 p.m., the Commission Meeting was recessed, to reconvene at 9:00 a.m. on Friday, September 24, 2010.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Friday, September 24, 2010
9:11 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
HERMAN GRAY, MD, MBA
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
JUDITH MOORE
ROBIN SMITH
STEVEN WALDREN, MD, MS

LU ZAWISTOWICH, ScD,
Executive Director

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CHAIR ROWLAND: Good morning and welcome to the continued deliberations of MACPAC on its first official meeting, and we're pleased this morning to be able to review some of the other work going on within the Government and within GAO and in the research community that will affect the deliberations of MACPAC over time.

I think we had a most productive discussion yesterday of some of the access and payment reform challenges that face Medicaid and CHIP, and today we're especially pleased to be able to open the discussion with Cindy Mann, who has responsibility at HHS over the management of Medicaid and CHIP, and Penny Thompson joining her as well, and Jennifer Ryan. So welcome to Cindy, Penny, and Jennifer, and we are very pleased to ask you to just provide us some background on what your plans are, what you think some of the major issues are that we should be addressing, and how we can work in cooperation with you around some of the policy and data challenges. So thank you, Cindy.

MS. MANN: I've got to turn this on. Thank you all. Thank you for invite me in your first public meeting. It's very exciting to get the work underway, and as I said the last time that we all met, we are enormously excited about MACPAC and the potential that your focus on these very important issues, the potential good that it will bring to the beneficiaries of the Medicaid program and ultimately to the structure and operation and leadership that we would like to make sure this program has, both with respect to congressional interest and, of course, within the administration.

So what I have proposed to do, after some consultation with Diane and all, is to go through a little bit of our general priorities, which are exhausting, and what Diane asked pretty much is to not focus so much on the implementation of the Affordable Care Act, although obviously that's a major priority. So that will weave into -- so these are activities that we're working on now, priorities that we're working on now, and then, of course, each and every one of them relates specifically to the implementation of the Affordable Care Act. And what you'll see towards the end is that we firmly believe that for each and every one of these priorities, literally, data improvement, leadership around data, being able to see what's really going on in the program is critical.

So Penny is here. Penny Thompson is Deputy Director at CMCS, and what we'll do after my presentation, she'll give you a little bit of an overview of where we are in a pretty thorough undertaking, first to have done inventory on our data, which was needed, and then a needs assessment, and now a pretty aggressive planning period that we're in, and what we'd like to do is share that with you so that you have a sense of where we are and a little bit more detail as we go forward on data, and then we can have a

conversation. So hopefully that will meet people's needs, and we'll go ahead.

We would just like to start just by stressing what our mission is, which is, simply stated, to make Medicaid and CHIP the best programs they can be, and to contribute to the broader improvement of health care for all Americans. So not too ambitious.

Beneficiaries are, of course, our focus. That's the reason for these programs to exist, and so everything that we do, our litmus test in terms of our priorities and how we determine what we ought to do is with their interest in mind. But as indicated by the creation of MACPAC, partnerships are really critical to the success of Medicaid and CHIP, first and foremost with states because they run the programs, and then, of course, with the Congress, with researchers, with stakeholders, beneficiary communities, and so forth.

Our key priorities are enrollment, access, quality, and costs. So not sort of niche little ideas that we thought we'd go forward on. You know, when I came to Medicaid and tried to think about what the priorities were, it seemed like the priorities really ought to be what the priorities were facing the Medicaid and CHIP programs, and this was, of course, before the enactment of the Affordable Care Act. But if we're not focusing on enrollment, access, quality, and costs, you know, what are we doing?

So they are large priorities, and obviously we have key ways in which we are trying to drill down on those priorities, but they are, I think, the major issues facing the programs. So let me take each of those separately.

On enrollment, here are some of the things that we're doing, and it's vast, but I wanted to give you a little bit of a flavor. We're certainly promoting simplification strategies we have learned through the years, of course, through the experiences at the state and national level that simplification strategies are key. And, of course, this connects very well with the implementation of the Affordable Care Act where none of it will work without a vastly simplified Medicaid eligibility and CHIP eligibility system and coordination with the exchange. So it's the key to enrollment in the short term. It's the key to successful enrollment under the Affordable Care Act.

We have some new tools that were provided to us through Congress, financial as well as programmatic tools, through CHIPRA, through the Children's Health Insurance Program Reauthorization Act. They range from the performance bonus, which is financial incentives or support for states that do well in terms of enrolling eligible uninsured Medicaid kids, to new programmatic options like Express Lane and coverage options, for example, for lawfully residing immigrants.

There's also important things -- I know you talked about it a bit yesterday. There are some important provisions in CHIPRA about increasing match rates for

translation and interpreter services. So these are all very important aspects of access to care when we think about the beneficiaries' ability to actually enroll and stay enrolled in the program. ARRA financial support is obviously a very important area for maintaining enrollment, and we're very pleased that Congress extended the ARRA support for an additional six months. And today is actually the deadline for all Governors to decide whether they have chosen to accept the ARRA funding for the additional six months. So stay tuned, but I think we'll have a positive story on Governors' accepting that certification.

In addition to sort of the day-to-day business in a nuts-and-bolts and kind of leadership way, the Secretary herself has really taken leadership on the enrollment issue, particularly with respect to kids. And hopefully you all know but, if not, let me introduce you to a campaign that we have which is Connecting Kids to Coverage Challenge. This is on the first anniversary of the enactment of CHIP, so in February 2010, the Secretary announced a challenge to everybody to make sure that every single eligible child who's uninsured actually gets enrolled in Medicaid and CHIP. And thanks to our friend Jenny Kenney, we know there are roughly 4.7 million of those eligible but unenrolled children, and now we know more precisely than we have before exactly where they are residing. So we have a pretty aggressive multi-pronged campaign to go forward on the Secretary's challenge.

The other thing I want to mention on enrollment is that we have healthcare.gov, which is an HHS website now, and it is a multifaceted website that has information about health care programs, has information about the Affordable Care Act, but the particular enrollment-related component is that it has what's fondly known as the portal, which is a requirement of the Affordable Care Act. It was required that we get it up and running by July 1, which let's just say was a little bit of a scramble since the law, as you remember, was enacted March 23rd. But there it was on July 1, and it is the first floor of the beginning of a long road towards -- floors, roads, I am sort of mixing my metaphors there, but to get to a place where people can actually put their information in if they choose to through an Internet site and get information about their availability for health insurance. And it has access to private -- information about private plans. It has information about Medicaid and CHIP.

It is evolving. Speaking of data, it prompted us -- which was already in our plan but sometimes events allow you to accelerate your plan and get done that which you thought was important anyway, but now becomes important to everybody. We were engaged in a pretty aggressive effort to collect eligibility, cost-sharing, and benefit information on Medicaid and CHIP programs. Of course, we have all that information in state plans and in waiver documents, but we had never compiled that information, at least consistently

across states. So we pulled that information together. We went through a verification process with the states for the first round of data that was put on the website on July 1. There will be further improvements to that website, both in terms of the level of information on Medicaid and CHIP and on private plans, but also in the way in which consumers will be able to manipulate that data and really get better at being able to get more information. Right now it's presented in a fairly one-dimensional way. You can say what state you're in, you can say whether you are low income, you can talk about your family composition, and you can get information about your state Medicaid and CHIP eligibility, but it's not quite that decisionmaking mechanism that says, Ah, it looks like you may be eligible. And, of course, the ultimate stage of this kind of portal will be to actually get somebody enrolled through that mechanism, which is certainly envisioned in the Affordable Care Act that we get to that point, both at the federal level to the extent that we can and at the state level. The law requires that there be state portals.

So, again, it's an activity that we're working on now. Medicaid and CHIP actually is one of the more robust opportunities for enrollment for coverage these days because many of the other options that are available to people who are uninsured are not yet affordable for them. So we're very excited about working on healthcare.gov and moving that along.

So what we all know is that -- and we think it's always important to underscore this because sometimes people think: They keep working on eligible but enrolled; it must be that it can't be accomplished. And, in fact, it can be accomplished, and what we've seen consistently through the concerted efforts of states, of community-based organizations, of children's provider organizations, and leadership from the federal government is that we have seen success in the Medicaid and CHIP program in terms of the rate of uninsurance. The census data that just came out again showed a drop in uninsurance for low-income children due to the value of Medicaid and CHIP. And, of course, that runs completely contrary to the broader story that we're seeing this year in the census data as well as in recent years.

So it is no accident that that's happened. It's been pretty intentional. It shows we can and have made concerted progress, and Jenny's data show -- I'm not sure I have any of that data here. Jenny's data show that we've made progress in Arkansas and Louisiana as well as in Massachusetts and Vermont, all regions of the country. It also shows that we've got a lot of ways to go in a lot of different areas. So focusing on that is of key importance.

As we think about the enrollment priority that we're working on now in Medicaid and CHIP, and thinking about how it translates to the Affordable Care Act, I would say it's both -- that a lot of the activities that we have

been doing -- and, again, when I say "we," I really mean the greater community on promoting enrollment -- over the last 10, 12 years are lessons to build on for moving forward in terms of success under the Affordable Care Act. But it is also, I think, really important to stress that what we see in the Affordable Care Act is really a new paradigm, because in the past we have thought about eligible but unenrolled as we really ought to do something about it. And sometimes it works and sometimes it doesn't. And some states are more energetic, and sometimes it depends on what the budget looks like that year, and it comes and it goes. And it's never really said out loud except for a few places. We have actually some Governors who are saying that loud and strong right now. But it's rare that everybody stands up and says, "You know, if you are eligible, you have to be enrolled. You ought to be enrolled. It is our job to get you enrolled." And that's really a new paradigm shift.

So it's not just we should be doing more of what we know has worked in the past, but we should recognize that new paradigm shift. We cannot get our quality where we want it to and we can't get our cost containment goals where we want them to be unless we are successful in our coverage goals, unless we not only get everybody enrolled, but they are enrolled all year, continuously in the right program, without gaps in coverage, without churning. Only then can we focus on really making sure that access is there, that the quality of care is strong, and that our cost containment goals are able to be met.

Part of that new paradigm, of course, is that Medicaid and CHIP do not operate in a silo. So part of that new paradigm is that we need to make a system out of the separate component parts for coverage, and to that end, we have certainly been working very closely with our colleagues in OCIO in the department as well as with the IRS and the Treasury Department to think about how to marry the exchange enrollment, renewal, change of circumstances systems, the premium tax credit evaluation systems with the Medicaid and CHIP eligibility systems. It is what we are charged to do, I would submit, under the law. It is what I think the American public expects us to do if this is going to be a success. And it is certainly what we think needs to happen under the law. And while I won't say it's simple and there is a little bit of, you know, Mars and Jupiter when we get in the room together, we are making it work. There has been quite a bit of progress, and I'm very confident, actually, that we will be able to work out a system that states will be able to make use of and really make a seamless system work. And we can talk more about that.

So this is pretty much our vision of coverage, that it's really a three-legged stool; and if we're going to make it all work in 2014, we need to make that system of coverage. Medicaid and CHIP, as you probably all know, is the second largest -- will be the second largest source of coverage in 2014 for people under 65, second only to

employer-sponsored coverage. So it's not this program there off to the side. It is going to be really key and integral, and we need to make it integral as well as key to the success.

So, of course, getting people enrolled is not the only thing that we need to worry about, and of particular interest, of course, to MACPAC is some of the work that we're doing on quality and access to care. There's quite a bit here as well, so I'm going to touch upon some of the areas. There are others, and we can respond to questions and talk about it as we go through.

We are very much focused on looking at what we ought to be doing as a federal agency on adequacy of providers, providers generally for fee for service and provider networks in the context of managed care. You're all familiar with the fact that about 70 percent of our beneficiaries are enrolled in managed care. And, you know, it won't be a surprise to anybody in this room, but we don't have the data that we need right now to be able to measure that. I believe we have the authority and, in fact, the responsibility to be much more engaged in this work. We have Section 1902(a)(3), to be precise, which requires that access be adequate in the Medicaid program, that we look at it in the context of overall availability of providers so we can't manufacture providers if, in fact, none exist. But they should be pretty much comparable, that access, so the statute says, to what exists in the private sector.

So we are doing a number of things. Part of it relates to some of the data that Penny will talk about. One of the things that we have in mind is actually to create a formal advisory committee, which we think will sit sort of side by side with MACPAC, to be thinking about what the measures are, what the data ought to be, what the criteria ought to be. And just, you know, were none of us paying attention to this, know, of course, that the courts are. There is a legal provision in the statute. There is litigation about it in different circuits around the country. There's one case that's now actually sitting before the Supreme Court pending for certification. I'm not clear if the Supreme Court will take the case. So it's an area that even if we thought we should ignore it, we can't ignore it. And, of course, we shouldn't ignore it.

We also want to be spending time particularly focusing on children and children's access to care and the requirement that children get regular preventive screenings, diagnostic tests, and treatment when needed. And the data are pretty abysmal in this area generally for children and then for all -- the EPSDT data is pretty abysmal for children. There's generally, I was going to say, for regular mental health medical care and then also for dental care, which we've been looking at in particular. Part of the question is, you know, is the data accurate. The EPSDT data, this Form 416 that at least my general experience is that it both overcounts and undercounts. So one of the

first things for a work group that we're putting together in EPSDT is to see whether that really is a source of data to measure access that we think should continue or whether it needs to be changed or we need to go to a different set of data.

We also have a core set of quality measures that, of course, we were charged with developing under CHIPRA for kids, and first for Medicaid and CHIP with voluntary reporting starting to happen, and then more broadly for kids generally, regardless of sources of coverage, so all pediatric care.

Part of CHIPRA's quality initiative also provided grant dollars, and we have demonstrations now going on across the country that are very exciting and that we actually hope to soon have some preliminary information about at least strategies that we'll want to share broadly. It's really a terrific set of grantees.

Part of our quality and access to care initiative relates to HIT, of course, health information technology. It is not about digitalizing your medical records. It really is about driving better quality, and that's how the meaningful use rules are set up, and we really are now actively engaged in getting HIT implemented among as many eligible providers as possible.

And I want to always make sure that we're continuing to focus on progress on the home and community-based care side. I think particularly with the Affordable Care Act, the acute care services are getting a lot more attention, and with maintenance-of-effort rules and others, I think there's a danger given budget constraints of sliding backwards on the progress that we collectively have made on home and community-based care. So it remains a big priority for us.

This is a formulation of this agenda on quality and access that has been developed by somebody near and dear to all of us, my boss, Don Berwick, and it's something he calls the "Triple A." And it's really a lens through which we are now looking at all of our quality and access work, which is how is the experience of -- how can we be improving the experience of care for individuals and through the integration of care? What can we be doing -- and CMS is not necessarily the primary driver on this, but certainly a contributor to what can we be doing better on population health? What can we be doing about diabetes, about obesity, you know, about lead in poor neighborhoods and so forth? And what can we be doing very intentionally and focused on lower per capita cost? We think particularly if we are better at the experience of care and population health, in fact, per capita cost will go down. But we want to be very intentional about that and not just see that as a consequence.

So, again, looking at the Affordable Care Act where some of this quality and access and cost containment measures will be taking us over the period of time as we

move to implement some of the provisions in the Affordable Care Act, we have, of course, a very clear focus on dual eligibles. A new office on dual eligibles has been set up, and I hope you've all heard that Melanie Bella has chosen to join us as the director of that office, which is very exciting. We have changes in the law in terms of Medicaid payments for hospital-acquired conditions. And we have a new option in Medicaid and very much a focus at CMS on developing not just medical homes but health homes and broader integrate care and accountable care organizations. There's particularly demonstrations in the Affordable Care Act on global payment demonstrations, pediatric ACOs, and, of course, very important to the issue of access is there's a primary care provider increase for the Medicaid program financed by the federal government that goes into effect in 2013 -- 2013 through 2014. And there's some preventive care incentives which provides an FMAP increase, and those we're viewing very much side by side with the changes in preventive care in the Medicare program that are mandated by the Affordable Care Act and the new preventive care provisions for private health insurance, which actually just kicked in yesterday in terms of the six-month effective date for those provisions.

So this is, again, not a story that's unfamiliar to any of you, but when we think about access, when we think about improving the experience of patients, when we think about lowering costs, of course, we need to think about chronic care and we need to think about those who have the greatest medical needs. In the Medicaid program, you know, you can cut it in different ways. This is a cut that shows you that 5 percent of our enrollees account for more than half, 54 percent, of all of our spending. And we know those individuals are not getting consistent coverage. I was struck the other day when I was in Massachusetts and they were telling me that dual eligibles -- or one of the provider organizations in Massachusetts was telling me that they put about five of their workers and instead of providing care, making sure that dual eligibles don't lose their Medicaid eligibility at redeterminations. Well, if we can't stop churning for dual eligibles, where are we going to stop churning? Really, their situation is not the most fluid of all situations.

So enrollment is key for them, remarkably, and we have to think about that. But, of course, the delivery of care and how we're organizing care, how we're making sure they get access to the kind of care that they need, and I think most notably, this is an area where if we deliver that care in a better way, we will see lowering of costs.

And access is really key to that because we need to think about what are the care delivery systems that are appropriate for people with chronic care. So it's not just, you know, do we have enough primary care physicians, which, of course, is a big issue in the Medicaid program, but do we have enough nurse practitioners, do we have enough

translators, do we have enough people that are helping people with transportation to get to and from the support services and the medical care that they need. When you talk to folks deeply involved in providing the medical care for people with chronic illnesses, those are the kinds of services that are going to help us move forward with better and lowering cost. So we need to make sure that our definition of access and the kinds of capacities that we need to have in place take into account, you know, the better thinking about how to deliver better care to people.

So as I noted before I started the talk, all of this, in our view -- and those of you who know me know well that my first question, whether it's looking at eligibility, whether it's looking at access, whether it's looking at quality, is, well, show me some data. Let's look at what we know, let's look at the trends, let's look at the information. And we need to do a lot better as a community and certainly as an agency on developing our data and developing our technology. Technology is important to make all of this happen. Our three-legged stool is not likely to come to pass unless we take our old legacy eligibility determination systems and move them past the 1990s and into the 21st century, and to have lots of new ways of purchasing those systems, lots more efficiencies across states, lots more leadership by the federal government so that states don't have to be reinventing the rules every time they need to move forward. So we're focused highly on that technology, working with states, working with OCIO, working with the IRS again on those areas, as well as the question of data.

And, of course, tied to the question of data is performance standards and measurement. We believe strongly that without the Affordable Care Act we ought to be having clear performance standards and measurement in the Medicaid and CHIP programs. Certainly the Affordable Care Act requires us to get to that point. So we need to decide what it is we think is important, what is important, how we're going to measure it, and how we're going to ensure that we have the data. And I think part of that, given where we are collectively, is prioritization. What is most important to know now given that we have a lot of work to do to build our capacity on data and technology? And how can we develop a plan that's a multi-year plan that brings us to where we need to go? And that's a bit of what we've been working on that Penny will talk to you about.

And, of course, just as important as data technology is strong collaborations. All of this is a job well beyond -- as much as we want to be very pushy feds and have great leadership and provide enormous support for states as they move forward in this program, or these two programs, we need the support of MACPAC, we need the support of the kinds of people who are around this table, and the kinds of people attending this meeting today. And hopefully together we can really make an enormous difference. This is

a window of opportunity that we can't miss, and we're ready to jump in there. We're working hard to do that.

So why don't I at this point, a perfect segue to our mantra, that 2014 begins now, and have Penny tell you a little bit about where we're going on our data analysis. Then we can open it up. Does that make sense, Diane?

MS. THOMPSON: Thanks, Cindy. So I'll just spend a few minutes sketching this out. This may be a subject that we want to dive into in deeper detail together at some subsequent meetings. We can also make sure that you guys have information about some of our current data and current systems so you kind of know what we have in hand and what we think about it in terms of its quality and adequacy and timeliness and so forth, so that might be helpful for us to provide to you and we'd be happy to do that.

I just want to talk a little bit about kind of the structure, and right now the kind of buckets of activity that we have in play so that you're aware of them.

As Cindy mentioned, it's hard to have a conversation about the direction of the program without data and evidence, and it's clear that right now, as we look at our, within CMS, state of data, the right data isn't available to the right people at the right times for the right kinds of conversations that we're seeking to have, despite the fact that there's a lot of data being collected. The data that people are receiving now is voluminous in some ways and totally inadequate in others. So we really have to think both about the fact that we need to be more efficient about what we're doing and why we're doing it and also a little bit more ambitious about what we want to do with the data that we have in front of us.

So we created a structure called the MACBISC. We're starting this new naming convention where we're branding everything with "MAC," so you should like that, and it stands for the Medicaid and CHIP Business and Information Solutions Council. And it was really convened across CMS in recognition that a lot of people in the agency, not just those of us within the program office, need, want, and use Medicaid and CHIP data. But those efforts were not very well coordinated. So that governance council is co-chaired by myself and Julie Bond, who is our Chief Information Officer, and it includes people from a variety of program offices throughout CMS. It includes people from the Office of Financial Management, people from the Program Integrity Office, people from the Research and Demonstrations Office.

And one of the first things we did, Cindy mentioned taking an inventory of what people were doing and just bringing those folks together and having that conversation to open some eyes as to how much data was being collected from States in different processes. Some of it was just a bubble off from data that somebody else had, but there really was not kind of an enterprise point of view about what it is we were needing as an agency and then consolidating some of that and making that known to the

States and then ensuring that the way we were collecting the data was efficient and effective.

So the MACBISC group is really about governance and strategy, and the strategy is really about, Cindy mentioned priority and phasing. We know that we have a long way to go, so what is it that we need to tackle first? What is practical to get done in the near term? How can we improve things most immediately? And then how can we continue to build on some of that momentum to get to longer-term capability?

And we've bucketed our priorities at the moment into three different jobs which we, because we are very creative people, have called Job One, Job Two, and Job Three.

[Laughter.]

MS. THOMPSON: And Job One is really -- a shorthand way of thinking about that is to think of it as redefining MSIS. There was a project a couple of years ago that was called MSIS Plus that some of you may be aware of that was an attempt to try to think about expanding the data elements that were collected under MSIS. We wanted to take that further.

CHAIR ROWLAND: Penny, for the record, could you just explain what MSIS is for those who may not --

MS. THOMPSON: Thank you. So MSIS is a key reporting and statistical information system that has been in place for a number of years where States submit data to CMS around claims and encounter data. By the way, the encounter data is quite spotty, so we can have a longer conversation about the quality of that and where do we get it and so forth.

But it stands for the Medicaid Statistical Information System, and that name is very important because it was really built as a, literally, statistical reporting system. What we really want to do is change that in a way that moves it from a statistical and information reporting system to a real platform for operational and administrative decision making. So it has to do not just with the amount of the data that we collect but how we collect it and how we use it and purpose it and to whom we make it available.

So we really want to consolidate the data requests that are going out to the States and have one kind of consolidated feed from the States. We want that to be coming in on a more frequent basis. We want to ensure the quality of what's coming in to us with a variety of different tools. One of the things that we want to do is move to a more standardized set of definitions and terminologies for the data that we collect so there isn't a significant transformation effort, and then make that widely available to people, to States to use, to people like you all to use, as well as to various folks within CMS.

Job Two is really focused on the data that we have on paper about State plans and waivers. So right now, if you wanted to ask the question, what do States cover, for

whom, you would go largely to regional offices and you would flip through pages, and that's how you would find that information.

Cindy mentioned healthcare.gov. When you go to healthcare.gov, you'll see quite a bit of information there around the Medicaid and CHIP programs. That was a very significant lift on our parts and on the States' parts to go through our documents and arrive at a consistent answer about eligibility and benefits. So we really want to think about how to get that information into a more structured and electronic form and make that more, again, widely available.

Job Three is really about the performance data. So that includes things like how does clinical data from Electronic Health Records come into play? What are the measurements, both in terms of looking at things like access, but also looking at efficiency of program administration. Right now, if you asked us about how long does it take someone who arrives at a door to go through an adjudication process and become enrolled, we would not have that information consistently State by State.

So we want to be sure that we're looking not just at outcomes and not just at experiences within the health care system, but also at how States are administering programs so that we can promote best practices and we can understand the relationship between decisions in program administration with some of the experiences of people within the health care delivery system.

So it's a big agenda with a number of different pieces. You guys are sort of coming together at a great time for us to be a sounding board for a lot of those kinds of scoping and activities and we'd love to spend time with you talking about kind of our current thinking on each one of those jobs and get your advice as we move forward. We're really trying to work on a time line where we spend some time with the States, spend some time with other folks that have been deep into and using our data and wishing for different kinds of data to be available, and then really formulate a plan that we start executing by the end of the year.

CHAIR ROWLAND: Well, thank you, and since one of our charges in the statute is to look at data and State information, as well, I think this has been a great opening for the discussion and I'll now entertain questions from the Commissioners.

VICE CHAIR SUNDWALL: I'm going to take the prerogative of speaking first because I have to leave. I apologize for that. But I really appreciate your coming early and giving us this overview.

It's all very interesting to me to see the energy and creativity you have related to Medicaid. The only thing I want you to understand, which you do completely -- I feel a little silly to say this, but your enthusiasm is not shared by a lot of States. It is really difficult for us who are on the ground trying to balance budgets, which

aren't in balance altogether. And so with the good intentions of expanding coverage, which are laudable and I think all of us in health care wish that were the case, because as a Public Health Officer, I believe having insurance is a factor in having good health, given timely and appropriate care.

But I just hope you'll factor in, if you will, the ambivalence that we might seem to be demonstrating or the challenges we face, whether they be budget or philosophical differences with the legislatures we work with. I see this mammoth energy and interest and intellect kind of churning to get this done, but I hope you also appreciate that there is some equal and opposite forces at work that is compounding and making our lives difficult at the State level. Thank you.

MS. MANN: I appreciate that, and I think it's a very appropriate point to raise and we can be in our "let's just make it all happen" mode. You know, what we need to make sure we have the opportunity to do is have some thoughtful dialogue with people of different views, or concerns, let's put it that way.

For example, on the cost side, there's no one more committed to reducing costs in our health care system and in Medicaid than Don Berwick and believes firmly that it can be done, that there is so much waste and misuse of our health care resources writ large, not in the Medicaid program specifically, but just how the care is delivered. You know, I put the graph on about five percent of our beneficiaries accounting for 54 percent of our costs to show there's enormous opportunities there.

So we are not tone deaf to the issue of cost and believe that there are really lots of opportunities to make health care generally and Medicaid as part of that to be much more efficient. So if we can get beyond the, it's too costly, I mean, at some point, there's a philosophical difference as to whether or not there should be a publicly-financed program and we may not be able to, at least in my pay grade, address that.

But I do think that we see quite a bit of enthusiasm among the States in terms of moving forward, you know, people tearing their hair out saying, how am I going to afford it? How am I going to make it work? Do I have enough time? So not without a lot of loss of sleep at the State level, but I've actually been excited about it.

Legislative feelings about it, you know, may be different, but I think there's a lot of commonality if we can get to a point where we can have some good discussions.

VICE CHAIR SUNDWALL: Well, thank you, and I couldn't agree more. As I say, there's reservations, but there's not lack of interest. We certainly are proceeding to implement every aspect of the health reform while at the same time suing the government on its constitutionality.

[Laughter.]

VICE CHAIR SUNDWALL: So it's a dual track, but I

think we'll see what the courts say.

MS. MANN: I had a great experience in Texas yesterday, a very energetic panel by the Health and Human Services Commissioner and the Insurance Commissioner, notwithstanding the litigation, so you are exactly right.

VICE CHAIR SUNDWALL: Well, you have in Utah a friend of Don Berwick and Brent James who shares his enthusiasm and believes there really are savings to be made in system reform. So thank you for working with us. I look forward to a long association.

COMMISSIONER CHAMBERS: I'd just like to compliment the Secretary on the initiative on enrolling the five million uninsured kids. When we heard from the Congressional staff members back at our initial meeting in July, there was concern about State readiness on eligibility systems, particularly linking with the exchanges, and there was some questions about CMS's policy on maturates for States. At least the Hill staff were saying that in the last administration, there had been a reduction from the 90 percent match on systems changes that was an administrative decision. Is that still an issue, and is there any intention of making more money available to States, because some of us -- well, all of us deal with States and local level of seeing the dysfunction that is there now and the fear is, are they going to be ready for 2014.

MS. MANN: It is the first item -- it's the first, second, and third item that comes up when we have our discussions with States about what they're worried about and what we're trying to help them with, which is get their systems to a place where they need to be to have that three-legged stool work well for people.

We're looking at all possible avenues. We're coordinating closely with the OCIIIO people on the exchange funding. There's planning grants that are just being provided for States on the exchange. That is to build the exchange. On the other hand, part of building the exchange is to think about interoperability with Medicaid, so we're working closely around allocating those costs as well as bringing Medicaid to the table in terms of dollars there.

And we are also, as I mentioned, really trying to think about how to streamline the process for States so that every State is not trying to, you know, is trying to change to MAGI and link up with the exchange, is not having to. If they want to, maybe they can, but not having to, anyway, reinvent the wheel and really move along through some collaborations of States with similar systems and similar issues that we would then support.

So I think both on finances, on the collaboration with the exchange, and on us providing technical support to States in a collaborative way, I think we're really focused on at least recognizing and doing what we can to move States to the place where they need to be.

COMMISSIONER COHEN: I suspect I am sort of preaching to the choir, and I'm not sure exactly what the

question that will come out of the end of this comment, but as I see the development of this, you know, we have Medicaid and CHIP and obviously incredibly important programs that can use improvement but that do phenomenal work now in covering adults and children and the elderly and the disabled, and we're layering on top of it subsidies for health insurance for people at much higher levels of income done through a different mechanism.

And I guess I'm quite concerned that we're sort of in some ways intensifying different standards, or there's a potential to sort of intensify different standards applied to the programs in terms of how eligibility is determined, how sort of fraud, waste, and abuse is addressed, because they're being addressed in sort of different programmatic ways.

And it is what it is and that's how the legislation is focused, but I guess my question is there's going to be many, many more people getting subsidies from some level, funded by some level of government in 2014, and I guess my question is, how do we keep our eye on parity so that we don't have a situation where people who are covered by one set of systems, Medicaid and CHIP, are subject to different kinds of rules although they are getting the same -- not exactly the same subsidies, not through the same format, but they are getting subsidies just like other people are getting subsidies, and just sort of making sure that there is some sort of parallel thinking and evenhandedness about how different rules are applied. Are you sort of focused on comparing the programs?

MS. MANN: Yes, intensively. But you're absolutely right to raise it, because I think the first vision of that coordination is around enrollment, right, and of course the statute uses MAGI, Modified Adjusted Gross Income. Medicaid and CHIP will convert to an entirely new income eligibility standard that is the same as the standard used for the premium tax credit. So that's one mechanism.

But there are so many other features, and we are looking at, for example, plan participation, plan requirements. What are the managed care requirements? What are they in Medicaid? What are they going to be in the exchange? Are they compatible? Are they different? What's our error rate measurement standards going to be? Are they compatible with our enrollment goals, with our coordination efforts? Are they consistent across the premium tax credit/exchange and Medicaid and CHIP?

So I finally exercise a little bit -- the challenge is finding the sweet spot, right? The sweet spot to me is where you can achieve simplicity and coordination while recognizing some special features of each of the component parts. Medicaid is unlike some of the other components to that three-legged stool. It serves a very low-income population. It serves a population with special and unique needs, often much higher medical needs. And we can't lose sight of that uniqueness of our population and

our ability to serve them. And at the same time, we want to see that smooth and coordinated system in both plans, fraud, waste, and abuse, and in enrollment.

So we are trying to think through, hence it'll take a village because there's a lot to be done, all of those areas and think about where that sweet spot is and really welcome that collaboration on it.

COMMISSIONER COHEN: And if you don't mind if I do a quick follow-up, for populations that won't be eligible for MAGI, for example, it seems as though there is some potential for them to be a little bit left behind dual eligibles and medically needy in some States, things like that. Are there efforts afoot to try to do simplification and other things for those populations, as well?

MS. MANN: Well, certainly what we're trying to do is we're thinking about, with States and our other Federal partners, the mapping out of the trajectory of how enrollment will work is not just looking at the MAGI population. Just so to make everybody clear on it, what the statute says is that for the newly eligible groups, people under 65 who are eligible based on their income, the income is to be determined using this Modified Adjusted Gross Income. But for the people eligible based on disability and for people over 65, Medicaid will continue to use a net income calculation. And the goal of that was to not disenfranchise the disabled population and the elderly in terms of making sure they still had a route to qualify for Medicaid.

But sometimes people don't know whether they're going to qualify based on disability or they're going to qualify based on income, so when we've been mapping out what the possible routes of the enrollment process will be, we've been imagining people in those different situations and thinking about what the different options are. Obviously, States will have a lot of discretion to decide how they're going to design their systems, but what the options are to get somebody through the system as quickly as possible while again, in a simple way, while still maintaining the ability for people to show their eligibility under alternate paths.

You know, and it goes back to, a little bit, it goes back to Richard's comment, too. It's not that hard to think about if we've got the good technology to back it up, right? But that's not where we are in many eligibility systems right now at the State level.

COMMISSIONER WALDREN: Well, thank you very much. I think the data is one of the biggest challenges as we move forward, and I'm glad you guys are taking it on kind of head first.

You know, when I think about standards and the technology, there's kind of three big levers you can pull. You can kind of mandate what has to be done. You can kind of be the de facto big gorilla and say, if you want to do business with us, you can do it that way. And I see those as two very easy levers for the Federal Government to do

relative to CHIP and Medicaid.

There's also one with value, that if you drive value, that you'll get adoption, and we heard from the D.C. and the Kansas Medicaid programs that -- what I heard from them is that the value is data, infrastructure to manage that, and then the whole analytics and expertise to say, okay, we have the data. What should we do differently?

So I see that as a potential for us as a commission to think about, especially as we think about our early warning system we are asked to look into. Technology has its own problems, but usually the biggest problem is kind of culture. So I wondered what type of kind of data collaborations are you guys doing today with the States around kind of real-time production data, not kind of batch and forward. And based on that or your own experiences, do you think there's a cultural issue there or do you think that there is the ability for a program to be created, either it be that you provide the infrastructure or you do something like Vista where it is free, open source and they can use, but you're able to standardize that to get that data back. So maybe about that data collaboration. Is that something worthwhile, and if so, I think that's something that we at the Commission should take up in a longer discussion.

MS. THOMPSON: There was a lot packed into that question.

[Laughter.]

MS. THOMPSON: First of all, I want to emphasize that, actually, while there are going to be some requirements that we're going to have to develop out of the legislation, the Affordable Care Act has various requirements around reporting, around -- there's a provision around encounter data reporting, there's a provision around reporting out of MMIS, there are other provisions that embed inside of them the requirement to do certain kinds of reporting -- it is our framework that what we want to do is do something that has value and makes sense for the enterprise, and the enterprise includes States as they manage their programs.

So to the extent that the data environment that we create provides more information, more information in context, some external data that the States would otherwise not have, some business intelligence tools, some capabilities that are of value and importance to States without States having to make those capital investments themselves, that's a very key part of our strategy.

You know, in terms of some of the other issues about Vista-like approaches and so forth, I think, in general around our technology deployment, we see ourselves moving towards more of those kinds of opportunities. There's a lot of work that needs to be done to think about how to make that happen within a Medicaid and CHIP program. The way that right now we capitalize technology, it historically has been State by State by State, matched by

the Federal Government State by State by State.

I think that we see, as do States, many, many opportunities to change that dynamic, and more and more of a desire to do so. It is not just funding that is our enemy in getting to 2014. It is also time. And we're not going to get there if we do business the way that we've been doing business. So we have to think about a different way of working together and a different way of thinking about creating assets and sharing assets across the entire community. And so I think that's very much on our minds.

CHAIR ROWLAND: In our discussions yesterday, it kept coming up over and over that as we look at access, as we look at payment, we need to get inside the black box of managed care and the various forms of managed care. Can you speak a little bit to some of the challenges there and some of the potential plans, since that is clearly an area where we will have to be taking a hard look, as well?

MS. THOMPSON: So this is an area that actually we're engaged in some rulemaking right now about. The Affordable Care Act, again, set a requirement for States to report encounter data or subject to FFP penalties if they fail to do so. So that means we have to define what we want in terms of encounter data, what adequate submission of encounter data means, how we will assess whether or not people are complying with that part of the statute, and so forth.

But I think, in general, the encounter data issue is actually in some ways not dissimilar to some of the issues that we have on the claims side. We have not specified a great deal to the States about the source of data, so if you think about how we collect MSIS data today, which contains some encounter data based upon whether the States run it through their MMIS systems or how they might send it to us, we don't specify from what system. We don't specify the process for cleaning the data. We don't really specify a whole lot about how States actually construct the file submissions to us.

So I think that part of what we have to tackle, and this is just more challenging on the encounter data side because States collect encounter data themselves in very different ways and use it themselves in very different ways, unlike running a claims system, where everybody is running one and everybody is making payments based on the claims system. So what will we say about our expectation about how States are bringing in that data and how they're ensuring the quality of that data and whether or not -- what steps they're taking before sending that data to us. I think there's a great deal of discussion that we should be having about how to make sure that that's what it should be.

Just add the last point, which is that we don't want to do that out of context, either, of what we might want or need for other purposes from plans on the Medicaid side of the house. So one of the things that we want to think about, because we don't want to impose different sets

of rules or different definitions on plans, is how to make sure that we are doing something collaboratively with Medicaid as we deliver those requirements.

MS. MANN: And I would just also add, I think it goes to your last point, which is States have enormous need for good encounter data, as well. So it's tapping what their needs are for it so that it is not, again, the big, bad Federal Government. Yes, we have some statutory responsibilities to collect the data, but it is easy for them to not get -- easy for all of us to just fall into a, we're not getting the good data from the plans, but they wish they had it, as well.

So I think it's better to be working together and say, what do we need to manage and run these programs together and then how can we get there. So that's very much our approach. States need it as much as we do, and in part, it's our lack of providing some leadership over the years on it that has just allowed it to kind of atrophy. It's not the crisis of the moment and so you don't, as a State, spend time developing it or insisting that your plans come to the table and provide the data in a reliable way.

COMMISSIONER HOYT: Besides improving the quality and quantity of encounter data, are you guys discussing possibly some way to move the States towards reporting it the same way? It's kind of the bane of researchers' existence and everybody else is that not only is it sporadic or inconsistent, even when you do get it, then people haven't defined things the same way.

MS. THOMPSON: Yes.

[Laughter.]

MS. THOMPSON: I mean, I think that one of the challenges that we've had over the years with all of our data activities is there's a lot of variation about how people define terms and how they collect data and their environments and then what they're sending. Therefore, there becomes a big transformation effort that is never 100 percent happy to try to put that in kind of a single data model and make that available to people, and then people are always having to try to think about, but in this State or that State it's not quite true, doesn't quite mean the same thing, et cetera.

So we'll see how far we can get, but I think that the standardization of the information coming in and the agreement on that will both make life easier on the States in terms of how they submit the data and easier on us in terms of making that data quickly available to people and have confidence in it.

COMMISSIONER HOYT: And on the managed care contractors, it drives the MCOs crazy to be -- if you're in five different States and have the encounters reported differently in each State. It's just a nightmare for them.

MS. MANN: You know, and I think there has been a lot of -- what I've learned over the years from a lot of conversations with States on this topic is there's a little

bit of a sense that, oh, we should -- it's easier for the States if we give them a lot of flexibility on those definitions. And then at the end of the day, people are putting out data all over the place about their business and nobody's quite clear what it means, and that's not a comfortable position for States to be in.

You know, sometimes I have to call a State and apologize in advance. We're going to put out this data and it's going to say X, and I know that's not quite how you put out the data in your State, and that may cause issues.

I don't think we're doing ourselves a lot of favors by not having comparability and I think many of us from different vantage points have come to that. Obviously from a researcher perspective, it's just impossible. But I think there's lots of good reasons to be getting to comparable data.

CHAIR ROWLAND: Well, we certainly have lots of issues that we will continue to want to work with you on. Data is one, and obviously you need good data to make policy. You need good data also to be able to examine the impact and we'll need good data to be able to recommend how to put together an early warning system. So I think this is the first of many conversations and we look forward to working with you and thank you for joining us today.

MS. MANN: Thank you all.

CHAIR ROWLAND: And since we're on the theme of states and what some of the challenges for states are, I want to welcome Alan Weil who is joining us this morning to take a little look forward toward 2014 and some of the challenges that health reform has brought forth for the states and trying to figure out how to put in place not only the broader health changes, but specifically some of the Medicaid issues as well. Thank you, Cindy, Jennifer, and Penny for coming and joining us first.

So welcome to Alan Weil, the Director of the National Association for State Health Policy and a former Medicaid and Health Finance Director in Colorado and an expert on many of the issues that we will be facing at the Commission.

MR. WEIL: Thank you, Diane, for the invitation to be here this morning. NASHP, if you're not familiar with us, is an independent academy of state health officials dedicated to improving health policy and practice. Your member, Trish Riley, was our executive director for about 15 years, and it's a terrific opportunity for states to learn from each other.

We are, as Dr. Sundwall noted, states are struggling with mixed feelings about what they are confronted with, but I think there's a tremendous amount of enthusiasm about the potential here.

What I'm going to do is just spend a few moments talking about what the state roles are in implementation. My presentation derives from a short paper we developed where we identified, based on the input of our state

leadership, ten aspects of health reform implementation that states have to get right in order to achieve the potential of health reform.

We explicitly did not take a programmatic view. We looked at broader objectives, so I'm going to try today to take that thinking and focus it through the lens specifically of Medicaid. I would say that our work has been shaped not only by people like Trish. You heard from Julie Hudman and Andy Allison yesterday. Those are active folks in our organization. Donna, we go a ways back, Sharon, you and your staff. We have worked with state officials around the country.

So we've identified ten areas of focus, and I will just quickly give our thumbnail of what we think the intersections are between these ten areas and the Medicaid program.

So our first priority for state implementation of health reform is to be strategic with the insurance exchange. It's a tremendous amount of work to be done to set these up. I won't go into the details of that, but the Medicaid link here is critical, which is particularly in states that are seeking to have a more active role as purchaser through the exchange, driving quality, driving value, driving performance.

Those strategic objectives must be aligned with the purchasing strategies of the Medicaid agency. If you're going to be successful, you want to have a consistent message to the plans you're contracting with, to the providers of services, to the patients for what their expectations are. So aside from all of the work to be done around the insurance exchange, the integration of strategy with the Medicaid program is particularly critical.

The second area of focus for us is to be an effective regulator of the commercial insurance market. Again, this is not a core Medicaid role, but it has tremendous implications for the Medicaid program. Effective regulation of private insurance has an effect on the burden on the Medicaid program if people receive the services that are covered in their benefits.

If high cost patients are covered by private coverage as a primary source of coverage, then the Medicaid pick-up for the wrap-around, if they're also Medicaid eligible, is going to be smaller. Effective risk adjustment will assure that commercial carriers are interested in providing care to higher cost folks which will reduce the burden on the Medicaid program. So Medicaid has a tremendous interest in the affect of regulation of the commercial insurance market even though it's obviously not a core function of the Medicaid agency.

Now we move into some more Medicaid-focused areas. Our third priority for effective implementation -- and by the way, these aren't in priority order, but they're the third in the list. I guess this is our version of priorities one through ten, creatively named.

Number three is to simply and integrate the eligibility systems. This is a tremendous issue for states, one you've already heard about we could spend a great deal of time on. The core notion here is that by statute now, under the Affordable Care Act, every American has access to some source of coverage if their income is up to 400 percent of poverty and they have other avenues available to them above that.

That's a great model, but to actually make it the reality requires a redesign of eligibility and enrollment systems. The cornerstone here is simplification. Cindy spoke about the statutory simplification of eligibility standards, but that's just on a piece of paper. The question is, do we give it effect out there in the real world. Remember, most states rely on county-based eligibility systems, highly decentralized systems, often paper and pencil, or with some computer component to the eligibility termination, but not fully automated.

We can't just layer modified adjusted gross income on top of these incredible complex systems. We have to rebuild the systems, hardwire into them a more simple structure, a more simple interface, a more simple set of expectations of clients as they apply for benefits and as they interact potentially with Medicaid as well as the exchange.

And transitions are a real weak link in our system right now. We talk a lot about redeterminations, churning, all of these things that need to go away if we're going to have continuous coverage. So clearly, we are going to need to bring people back through the system periodically to reassess what they're eligible for, but it can't be that the default is if you don't fill out the paperwork or we can't figure out what you're eligible for, we just let you drift off into the ether and pretend you don't exist anymore, and then you have to start from scratch in a new system.

We need to build into our systems effective transitions of coverage so that when one system finds that you're no longer eligible, you don't have to start again when you go through another. And states will tell you that federal leadership and funding are key here.

The conversation you just had about the need -- with federal standards around eligibility levels, it is questionable how much sense it makes to develop eligibility systems at the state level when the terms of eligibility are going to be so consistent across states. And states, I think, are open to a much higher level of involvement of the federal government in this area than they were in the past.

The fourth area for success is to expand provider and health system capacity. We are talking about, on average, approximately 50 percent increase in Medicaid enrollment. Now, that's not the highest cost folks, but still, the demands on the Medicaid delivery system will intensify. And this will all occur in the context of state rate decisions over the past couple of years and in the next

couple of years.

In tight budget times, with maintenance of effort around eligibility, one of the few tools states have to manage their budgets is payment rates to providers. That's what we were seeing, states making their cuts now. So we're going to enter into an expanded program at a time of reduced rates with the exception of primary care in 2013 and 2014 that the federal government is going to pay for and we have to make this all fit into a system that actually has the capacity to serve a growing number of people.

Meanwhile, the safety net systems are going to be undergoing significant changes. On the one hand, you have new resources for community clinics. On the other hand, you have the reduction of the disproportionate share hospital payment program, and you have these providers, regardless of where they are, trying to figure out where they fit in accountable care organizations and the other transitions in the delivery system.

Ultimately, we also have areas where states have a key role like scope of practice and medical education. These are issues that states are hesitant to take on. They're politically challenging, and if we're going to deal with capacity we have to help states address these issues. They're not covered. Certainly the scope of practice is not part of the Accountable Care Act, and states have significant levers here to address this issue.

The fifth area for state success is to attend a benefit design. In the Medicaid program, of course, the expansion. States have the opportunity to use benchmark coverage designs as opposed to the traditional Medicaid benefit. That will have implications for access and cost.

How the Secretary defines the essential benefits package and how states determine what their mandated benefits are will affect not just the cost of coverage, but also the residual demand for services within the Medicaid program.

And as we are concerned about people transitioning as their income changes between the Medicaid program and the exchange or between Medicaid and private coverage, how closely we align benefit design between the Medicaid, the exchange, and the commercial market is going to have a tremendous effect on whether or not people have care continuity and are able to see the same providers as their source of coverage changes.

So benefit design is not just a cost issue. It's a continuity issue as well, and paying attention to it within Medicaid and beyond Medicaid is going to be important for that issue.

The sixth area, Cindy had it on her list, focus on the dual eligibles, more than 40 percent of the cost of both Medicaid and Medicare programs associated with this group. We do have some important statutory changes. We have changes in our special needs plans were defined. We have an expansion of the money follows the person demonstration

program. We have the new Office of Duals. We have the Center for Medicare and Medicaid Innovation. Great tools.

But as I put in the slide, new tools, old battles. We've had tools before, but we still have issues around the inertia and the financing of the institutionally dominant services such as nursing homes. We have Medicaid and Medicare coordination issues. And although there's now an office to talk about it, we still have questions about who pays and who gets the benefit. We're going to have to work those through in the context of all of these new tools, but it is where a tremendous amount of the cost and the potential for improvement lies.

The seventh need for successful implementation is to use your data. We could spend the whole day on this. You will spend the next year on it. What I can say at this stage is that throughout the statute, you see new data collection elements, disparities, wellness programs, utilization. I've had the list elsewhere.

And what you have been talking about is that Medicaid really does lag behind other coverage sources in the quality of data collected, obviously, particularly in contrast to Medicare, for some obvious reasons. But still, it's the reality. Meanwhile, you're serving a more vulnerable population and so, the need for data to drive performance and improvement is even greater.

I think the move to electronic records is terrific and it will be a great source of new data, but remember, also, that the population in Medicaid is particularly affected by social context which will not be part of the medical record: Income, which is not collected always or retained on the eligibility record as well. Race, ethnicity, language, and living circumstances, education, social context critical for health status and health improvement, not part necessarily of the medical record. So we can't just rely on that for the data we're going to need.

This is going to have to be a priority area. It doesn't matter how much you say the world should be better. If we don't have the data to monitor and improve, we'll never get there.

Our eighth priority is to pursue population health goals. This is, after all, the bridge between public health and personal health, and again, all I can say is that Medicaid has not always been at the table in discussions of broad population goals, whether it's obesity and treatments for it, whether it's diabetes and other chronic conditions, whether it's acute conditions.

We often focus on provider systems, we focus on public health initiatives, but the payer is often not at the table. Given the characteristics and the dominance of Medicaid as a payer, participation in the population health agenda is critical.

The ninth factor for success is to engage the public and policy development and implementation. And again, Medicaid and CHIP serve disproportionately

economically disadvantaged populations. This makes public engagement harder, but even more important, you need the feedback loop of the enrollee, of the providers to tell you whether or not your programs are working, not just the high level data. That engagement is critical for moving forward.

And finally, this all comes together as the goal to demand quality and efficiency from the health care system, which is, after all, sort of the embodiment of the triple aim that Cindy mentioned.

To do this, states need an over-arching strategy for health reform implementation that includes the Medicaid, roles for Medicaid, and then to assign tasks to the Medicaid agency, but coordinating them and integrating them with those that are going to be carried out by others. In particular, of course, the relationship with the exchange due to the focus there, the resources there, the purchasing coordination there.

So these are what we view as the key elements of success for successful implementation, a quick perspective on how the Medicaid program relates to those ten key priorities. Our organization will be working, already is, and will continue to work with states on trying to help them achieve these ten areas. I'd be happy to offer any additional comments or reflections that would be helpful to the Commission.

CHAIR ROWLAND: Thank you, Alan. Donna?

COMMISSIONER CHECKETT: Quick question. I know certainly in my experience in New York State, budget problems have led to some pretty draconian measures around staff of state agencies and in the Department of Health, and there's just a huge capacity issue for doing all the jobs that need to be done for health reform. What's your sense of that nationally? Is the money that's available now -- it's never adequate, but how far off from adequate is it, sort of looking around the country to make sure that states can do what they need to do?

MR. WEIL: It's pretty far off. The good news is that when the Administration first reached out to states subsequent to enactment of the Affordable Care Act, the states said, you need to understand. It's not just that we don't have people to do this for 2014. We don't have people to do it today. We don't even have people to apply for the grants that you're releasing that would give us more resources to do the things you want us to do.

And as Cindy very briefly alluded to, there was a grant program that went out, non-competitive, up to a million dollars per state around building the insurance exchanges. Those grants have to be awarded before the end of the fiscal year, which is a week away, so we will know within a couple of days. But we've certainly heard that the overwhelming majority of states did apply for those grants. I don't know how many will be awarded, but it's non-competitive.

So the good news is those are resources. The bad

news, from my perspective, is that they're tied to the exchange. Why is that? Because the statute is very clear about giving the Secretary the authority to use federal resources to do whatever it takes to build the exchanges including supporting states in the roles that they need to do.

But there's no similar broad authority for the Secretary to do whatever is necessary for states to do the Medicaid aspects of implementation. Now, the relationship between the two is tight, but it's not 100 percent, obviously.

If you're sitting down doing a work plan around the exchange, you're thinking about contracting the plans, you're building a Web site, you're doing all of these things, and if you're looking at your Medicaid work plan which has to do with bringing hundreds of thousands of new people into the system and redoing your eligibility and building provider capacity, that's not on your exchange work plan.

So we've all, at the state level, forgive the jargon here, but we've all dealt with cost allocation issues at the state level where you're figuring out which pot of money is going to pay for what. I don't think we know yet how the dollars in the exchange, how far into addressing some of the Medicaid issues, particularly around the eligibility systems, because those have to be such a tight handshake, will go.

We also know that there's debate about whether a broader spectrum of technology-based activities can be eligible for the 90-10 federal match as opposed to 50-50 administration. We know that those issues are being discussed.

So there's all this good work going on, but if you go inside a Medicaid agency today, you see that the people who are being asked to think about 2014, which is tomorrow, are also -- they have empty desks next to them. The people with the experience have been offered early retirement. They don't come in every other Friday because they're on furlough. That's the reality. And unfortunately, at this point, there's been nothing to change that because there are no new resources to address that.

So we do have some opportunities for certainly discussion on the IT and the exchange, but the core Medicaid function is badly understaffed.

COMMISSIONER CHECKETT: A lot of my question was around the exchange and you've addressed that, but I'm also curious, along those lines, Alan, what you're hearing from your contacts and members, are Medicaid agencies seeing themselves in the lead in the exchange design? How are they partnering with insurance commissioners, et cetera?

MR. WEIL: Donna, it's a terrific question and the answer is, it's still very much in flux and I think the story goes something like this: In the statute, there's a lot of talk about exchange and the early implementation, the

six-month rules today, were very heavy on insurance regulation. The state input around those provisions was, in the statute, designated the National Association of Insurance Commissioners to take the lead on a lot of that.

We know that the NAIC is developing model regulations and statutes for the exchange, so is the National Academy of Social Insurance. So there is work around that coming out of the insurance side.

So when you start and say, well, they're contracting with carriers, people say insurance, insurance, insurance. And then you go, by the way, these folks have to also work with eligibility, income eligibility, and insurance commissioners go, what's that?

We do solvency. We do rating. We don't interact at the retail level. Oh, and county-based eligibility systems? There's no language there. Meanwhile, the Medicaid folks are saying, we are so busy trying to get ready for the Medicaid side of the house, which again, in particular, eligibility systems. And these exchanges, boy, there's a lot to do there, but they're doing private and commercial and they have to build this new capacity. We're not sure we're there.

And so, I think what's been happening in the last six months is a really positive thing, which is both sides of the house, if you will, Medicaid and insurance, are starting to realize they can't do it alone. An effective exchange will require competencies that are based in insurance and knowledge of the insurance market, as well as based in Medicaid and CHIP and the knowledge of those programs, and you have to bring them together.

So of course, states have to make decisions about governance. Are they going to literally house the exchange within an agency, in an independent agency, and independent non-profit which is an option? I will be surprised if many of those end up literally inside one of the existing insurance or Medicaid places, because once you think about what the functions are, it's not a good fit.

So I think we're seeing the evolution, the realization that you can't own it in either place, but you need cooperation from both places, and we'll see that play out.

COMMISSIONER HENNING: I'm going to go back to the scope of practice issue since I'm a certified nurse midwife and one of the two nurse practitioners on the panel. I know it's difficult, but it definitely needs to be addressed. We've got a primary care shortage and we have out there a group of providers that can take care of about 90 percent of the health care needs of our population that are being under-utilized at this point.

As part of provider collaborative teams, they could be helping to take care of a lot of these low-income people if the scope of practice issues were addressed state by state. I will give you just a short little scenario. I worked for a federally qualified health center, ran a large

nurse midwifery practice there, and was recruited by another health center to start a midwifery practice.

When I went down there, the hospital where I applied for privileges, basically the OB section refused to give me privileges, even though I've delivered 2,000 babies safely. It was just because I was a nurse midwife. They didn't want the competition and they didn't want me in that hospital.

Now, thankfully, that's not the way it is everywhere, but that's the kind of thing that needs to stop.

MR. WEIL: Well, I'm certainly not an expert in this area, but I will say I think, again when Cindy described CMS Administrator Don Berwick's sort of view of how we get from here to there, he has a tremendous knowledge and background in working with the delivery system and looking for opportunities to reduce misallocated resources.

We often talk about waste, but we don't tend to talk about the waste of under-utilizing personnel. I also was at an Institute of Medicine meeting a few months ago and heard the CEO of Virginia Mason Hospital in Washington State talk about redesigning care and cutting the percentage of nursing time on administrative tasks from -- I'll get the numbers wrong, so I won't say them -- but from some embarrassingly high rate to some low rate so they could actually do patient care.

So their scope of practice there is, which is, I think, a subset of the broader issue of flows of care and teams of care and who's actually providing and what do those systems look like and what roles do different people play in them, there is no question that we have tremendous room in the current system to be more efficient.

We put it on the list, the scope of practice, because, clearly, under-utilization of talent is both -- it's wasteful, it's expensive, and it's professionally unrewarding, which makes it harder to draw people into the field. So I think the challenge is, how do you support the kind of discussions and debates that have to take place to move this issue forward? Because it's not like we haven't known that it's one we need to address.

COMMISSIONER MOORE: Alan, I want to go back to a slightly more narrow topic. I know that NASHP has a great deal of experience working with states on enhancing eligibility determination enrollment systems through some Foundation funding. But my memory is that that's related, in large measure, to moms and kids.

I'd like to go back to this subject of dual eligibles and ask you to reflect on what you may have learned in that work with those states that we could transfer or consider in terms of simplifying eligibility for dual eligibles and the transitions there which are extraordinarily difficult and problematic from a health status endpoint in lots of other ways, too, efficiency.

MR. WEIL: It's a terrific question. You are right that in its origins, our Maximizing Enrollment for

Kids program funded by the Robert Wood Johnson Foundation is focused on children. We are, in the context of health reform, in conjunction with the Foundation broadening the scope, but still our lessons learned, our early work, has been focused on the moms and kids.

What I can say is that so many of the lessons out of the work around kids, particularly in pre-health reform where we still had the complex rules, are completely applicable to the other groups. I mean, what it starts with is looking at your processes and collecting data throughout your enrollment systems to determine where you are losing people.

How many people come in the door? How many of them make it from the beginning of the door to the documentation necessary to determine eligibility? How many at renewal are renewed and if they are, what are the hurdles? And if they aren't, is it because they again failed to return a form?

A lot of the work we have done, first of all, has to do with gathering the necessary data because if you have a paper and pencil system spread among 50-something counties, even asking the question, how many of the people who walk in our door to apply for eligibility even make it to the end, it's hard to get that.

In response to the question about data for a process flow as opposed to batch, you certainly don't have that data in real time. You might have it months later when someone sits and counts the sheets of paper. And so, having systems that generate in real time usable information to enable you to do things is key.

Then you need a culture, which the Federal Government has a role to play in, of not just being worried about errors of the kind of letting someone on who isn't eligible, but acknowledging that you want to balance that with the negative side of keeping people away who are eligible.

The federal incentives have all been, don't ever let anyone on the program who isn't eligible. But there haven't been the incentives to get the people enrolled who are. And so, needless to say, systems migrate to a much more process heavy and keep people out kind of system.

And then there's an internal office culture, which is, okay, even if we have the data, how far do we go to push to assure that we get what we need as opposed to, well, we sent out five forms and they didn't get back to us. I guess they don't need this after all.

Hearing Cindy talk about the redeterminations and it's true. I mean, most of the status -- the life circumstances of the large majority of duals is pretty stable, certainly from an economic employment perspective, residential perspective. And so, you would think that the redetermination would be an area, again, where you could pick up a lot.

One of the clear things we've learned from moms

and kids is that if you put all of your energy, and there is always great interest in outreach and enrollment. But if you put it there and not in retention, you're filling up the sieve and it doesn't hold much water.

So I do think there are a lot of lessons. What there isn't at the moment is a lot of -- what there aren't are a lot of resources to go through this kind of process improvement step by step, state by state, around that population, but I think we know enough that we could do it better if we made that investment.

COMMISSIONER CHAMBERS: Alan, you just mentioned dual eligibles in responding to Judy's question. Back in the early '90s, states were really pushing the Federal Government as to federalize the dual eligible population as to get over this split responsibility in financing and cost-shifting to each other, in many ways.

Most recently, Melanie Bella, before she arrived at CMS recently, was working for the Center for Health Care Strategies with some states in looking at the sort of "statelizing," the states becoming the integrator of care and taking on the Medicaid responsibilities.

Do you see that as a movement, that many states share that idea, or is that something that you think will have much legs within CMS as a possibility for resolving problems?

MR. WEIL: I can't speak -- you have to ask the person before me about legs within CMS because I certainly don't know. My sense is, it's a leading edge issue, which means that you won't see states jump on a bandwagon like this until a few lead states try to work it out, just like a few states working through how to really seriously shift the emphasis from institutional care to community-based care.

We had a handful of states with very strong leaders spending decades making this happen, and finally they've shown, you know, you really can do it and the other states -- and they've worked out a lot of the state-federal issues so that you know what to expect in the discussion with the Federal Government as you try to go into those negotiations. That's something that most states can't take on.

I think it's a very intriguing idea. I've never personally been fond of the federalizing idea. I get the finances of it, but from a delivery system perspective, we're talking about the most complex populations, and the notion that sort of that should be managed by the Federal Government, the government farthest away from these people has never made sense to me.

I think the changing role of SNPs and the Office of Duals and the innovations, it's a place for us to start asking, can we have state coordination? But then you have to get to the questions that we never want to tackle like, you know, you have freedom of choice in statute and Medicaid and that didn't change in the Affordable Care Act.

So it's not like this is an easy thing to do. So

I think it's a terrific and interesting idea. I think if a few states can embrace it and work it through with the provider side, with the community of patients who are served, and with the Federal Government, we could see some others go. But I don't think you're going to see a mass movement until those very challenging issues are worked through in a more practical way.

CHAIR ROWLAND: Alan, thank you very much for joining us today. We're sure you're going to be asked back to join us many times in the future, and I think that's helped to give us a great context for some of the additional challenges that we'll face as we continue our deliberations.

MR. WEIL: Great. Thank you for the opportunity. Happy to do it.

CHAIR ROWLAND: And now I'd like to welcome Rick Kronick, the Deputy Assistant Secretary for the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services. And Carolyn Yocom, the Acting Director of the Health Care Division in the Government Accountability Office.

And following up on what has become a big theme today about data, research, evaluation, trying to figure out what goes on under the Medicaid program and the CHIP program, what some of the key issues are in trying to understand what goes on in managed care, how to evaluate and develop adequate early-warning systems for access differentials, how to measure access, how to look at differences across states, and how to really evaluate the way in which the programs are operating, both on the access side and payment side, we are glad to be able to hear from our colleagues who have been struggling with these same issues, doing some of the leading-edge research on these issues.

And so welcome, and we'll have, Rick, you start off your comments and then Carolyn to follow up. Thank you.

DR. KRONICK: It's a great pleasure to be here. Thank you for the opportunity, and congratulations to all of you on this wonderful adventure, much needed.

I actually am a Medicaid hound from way back. My first and probably most fun job ever, not counting this one, was as the Deputy Director for Policy and Reimbursement in the Massachusetts Medicaid program, the beginnings of health policy. And I've had a great affection for Medicaid and its great opportunities and challenges for the last 30 years.

What I'd like to do today is tell you about some work, mostly work that is getting underway. This is work that is many projects that will be awarded in the next week in ASPE, both in the Office of Health Policy, which I run, and the Office of Disability, Aging, and Long-Term Care that Richard Frank is the Deputy Assistant Secretary for. I've listed these here.

You asked me to do this in ten minutes. We have about ten projects, so I am just going to give a very high

level overview and would be happy to provide more information as requested.

CHAIR ROWLAND: We might give you 12 minutes.

DR. KRONICK: Twelve minutes, one for each. Okay. Thank you, Diane.

We're commissioning work to create a Medicaid Atlas of health care, somewhat similar in thought to the Dartmouth Atlas that has had so much attention over the last couple of decades and that has so shaped our thinking, many people's thinking about the delivery of health care and, you know, Medicaid, you know way better than I, totally different world. The Dartmouth story is always that, you know, more is not better and that supply matters a lot, in Medicaid, you know, I think a much more nuanced understanding of the world, but we don't really know very much about the patterns of care and the implications of those patterns of care in Medicaid, and with the availability of the MAX data, an increasing usefulness of that data, particularly as it will be linked now to the National Death Index, or at least to Social Security death information, there are, I think, tremendous opportunities to try to understand how people with schizophrenia or mental illness or, you know, various kinds of disabilities and behavioral health problems are treated in different places and what difference does it make. And so we are commissioning a project to do that with a focus on three areas: one, acute care for people with disabilities, one on behavioral health care, and then a third focused on the mix of HCBS and institutional long-term care. And this project also builds on other work that's going on in ASPE.

I'm not going to show you any results of any of these projects today except one slide that is from work that I did in my last job with Todd Gilmer in San Diego, a little bit of a teaser for what this atlas might look like, inpatient days for persons with disabilities who are receiving cash assistance, so primarily the SSI population.

You are all, I'm sure, familiar with the distribution of spending in which -- and spending, Southern States tend to be lower-than-average spending; New England, pretty high spending areas in Medicaid in general. Here you see that inpatient days looks quite different than this, and as the atlas is developed, we're hoping that there will be a greater understanding of these patterns.

The other thing to say about these data is that compared to Medicare, where, of course, we've had tremendous attention on geographic variation, there is, as you would all expect, I think, much more variation in Medicaid utilization and spending, twice as much at the state level easily, and for the most part, variation that does not look anything like Medicare. So the areas of the country that tend to be expensive for Medicare are not those for Medicaid.

The second project, we are commissioning work to try to understand a bit more about Medicaid managed care,

which was a vibrant research area in the 1990s but has been mostly neglected for a lot of the last decade. And given that it is the dominant form of care for people with -- you know, for mothers and children and related groups, and as we move towards 2014 -- and I should have started by saying that much of this research agenda is focused on trying to help understand how to better manage the program and grow it with the changes that will be coming in the Affordable Care Act, both in the quantity and quality of the program. And so we're going to try to understand what's happened to Medicaid managed care rates in about 20 states over the last decade, and to the extent possible, what's happened to managed care networks and access to care, particularly as we see some states that have been very tight on rate increases as have been associated with restrictions in the size of the network.

We have another project trying to measure access to primary care. This is motivated in part by the stories that came out of Massachusetts following the expansion of coverage there, that people couldn't get in to see primary care physicians, and we're sensitive to being able to monitor this as the Affordable Care Act is implemented. But a piece of this is also to try to understand more about access to care for Medicaid beneficiaries. This will be a secret shopper approach in which people call up and say, you know, "I need an appointment. Can I get one?"

Secretary Sebelius last February challenged states to enroll 5 million eligible but unenrolled children, and we are doing work -- and this is primarily internal -- to monitor whether states are being successful in meeting this challenge using both administrative data and survey data, as well as trying to understand something about the determinants of success.

We are contracting for and conducting an evaluation of the CHIP reauthorization, as called for in CHIPRA. The authorizing language here is very similar to the authorizing language of the original CHIP evaluation, although, of course, the world has changed tremendously. That evaluation was focused very much on the establishment of the program and documenting that. We will be focusing in this more on trying to understand the determinants of effective and ineffective outreach and enrollment practices, looking at factors, disenrollment and retention.

We'll also be doing an evaluation of Express Lane eligibility, this one not quite as far along as the CHIPRA evaluation, but working on that as well.

As you know, there has been a very large expansion of support for community health centers in the last administration, continuing in ARRA, and continuing in a very large way in the Affordable Care Act. There has been a large increase in the number of patients using community health centers. We anticipate a much larger increase as the Affordable Care Act is implemented. And we are commissioning work to try to understand the effects of these

expansions on access to care using survey data likely from the National Health Interview Survey to see whether people who live in areas where these expansions have been greatest, whether there's a reflection of that in their access to care, and then also trying to understand whether particular types of expansions seem to have been more effective, with a goal of trying to guide the future investments that are made.

The Affordable Care Act authorizes an optional benefit for states to establish health homes focused on improving care coordination for people with multiple chronic conditions. CMS is working on implementing this, and we are working with them on forming an evaluation of this new option.

We are also working -- and both the last piece as well as the next two are being run out of the Disability, Aging, and Long-Term Care part of ASPE, doing work tracking the rebalancing of long-term care, and this will also feed into the atlas that I discussed at the very beginning, trying to understand patterns of service utilization and expenditures and trying to understand, particularly in states that have expanded home and community-based services, what that means for the total number of people who are getting care.

We are doing a project trying to develop quality and performance measures for people with schizophrenia and bipolar disorder, you know, an area that -- as in other areas for people with other kinds of disabilities, much underdeveloped, but we're trying to make progress here.

And then almost finally, we are doing a lot of work with Cindy Mann and folks at CMCS as well as with the IRS on a range of issues around implementation in 2014. And I know you've heard from Cindy. I'm sure she -- I imagine she talked about some of this, but doing work trying to understand how much -- and help other people understand how much change in circumstances there is likely to be, and, of course, a tremendous amount; what the implications of that are for policies to make exchange and Medicaid eligibility really work for people in 2014, minimizing burden but also trying to deal with program integrity issues.

And then, finally, not so much focused on Medicaid per se, but Sherry Glied, who is the Assistant Secretary for Planning and Evaluation, is chairing a department-wide measurement and evaluation working group designed to measure what we're doing and evaluate what we're doing in the Affordable Care Act. As you likely know, the act itself has a panoply of studies and evaluations called for, but none particularly of the thing itself. And Sherry and others in ASPE and throughout the department are working on trying to figure out as we move forward what is it that we should be keeping track of and what should we be evaluating, and inevitably much of that will be dealing with Medicaid.

So thank you very much for the opportunity to present what I think is a very exciting set of work here

today.

CHAIR ROWLAND: We think it's exciting, too. That's the word we're using for our whole endeavor. It's our mantra now.

Carolyn, we'll have you share your results and then open it up to questions.

MS. YOCOM: Let's not get too excited.

It really is a pleasure to be here, and this is important work, and I want to spend just a few minutes sharing things that GAO has done in the past, a little bit about what we're doing right now, and then just some general thoughts about doing research in Medicaid.

I'm going to highlight just two of the list of reports here that we've worked on. The first one that the Commission actually asked me to talk a little bit about has to do with actuarial soundness. This was a mandate within CHIPRA, I believe, taking a look at the extent to which Medicaid managed care rates were actuarially sound.

Now, CMS in its regulations defined "actuarial soundness" as being developed in accordance with actuarial principles, with being appropriate for the populations and services being provided, and then also certified by an actuary.

We went in and we took a look at what CMS did in terms of its oversight for states, and then we also took a look at the data. And what we basically found is that in two cases there were some pretty big oopsies that happened on CMS' side. They had missed one state in terms of its review of -- its oversight of what is stated in terms of actuarial soundness, and then in a second case had done a partial review, not necessarily a full review of the whole system.

Second, and just as importantly, we found a lot of inconsistency across CMS' review of actuarial soundness.

And, finally, we found that the data that the actuaries were using and that the states were using, CMS might have some opportunities to help fine-tune that data and to improve it. CMS did agree with our recommendations and is in the process of taking some steps on this.

The second report that I'd like to mention is actually a series of reports. We've done about seven of them on the Recovery Act and Medicaid expenditures. There's \$87 billion, as most of you probably know, that has been allocated to states' Medicaid programs through an increased FMAP. And since those reports have tended to be sometimes 1,000 pages long, I thought I'd pull out the highlights for you.

Basically, key things that I think are of note is that states certainly are spending this money. If current spending trends continue, about 95 percent of that \$87 billion will be spent by the time it expires at the end of December. On the whole, states have used this money obviously for Medicaid, but then it has allowed them to free up state funds that they've had available. And common uses

of those freed-up funds have been to maintain their caseloads, maintain their program eligibility, and then in some cases to help finance their general budget.

There was a cumulative enrollment increase of about 18 percent, and that was very pretty widely ranging from 6 percent in Texas to about 35 percent in Colorado.

Lastly, there is, as has been mentioned yesterday and today, a lot of concern about program sustainability across state Medicaid programs. As you all know, the Recovery Act did limit actions that states could take in order to maintain their budgets, and we did find across 16 states and the district that 12 of the states that we reviewed as a sample had reported taking over 100 actions that were aimed at either freezing or cutting provider payment rates, and 55 of those were actual cuts, 46 percent were freezes since February 2009. And the providers most frequently affected were nursing facilities, clinics, and home health providers.

Some of these studies on this page, comparison between Medicaid and CHIP financing systems and improper payments and access to care, some of these are a bit dated, but I wanted to raise them because of the amount of time and effort and analysis that went into it. We did do back in the early 2000s a series of comparative reports looking at Medicaid and CHIP systems, everything from eligibility to payment. When we got to payment, we ultimately ended up reviewing just four states and taking a look at their fee for service and then also their capitated managed care rates.

In looking at the fee for service, we did find that overall Medicare paid higher than Medicaid, but differences between Medicaid and CHIP really were inconsistent. Sometimes CHIP paid more, sometimes Medicaid paid more.

When it got to capitated managed care rates, we did a lot of analysis. At the end of the day, the benefit differences and the construction of those rates were such that it really precluded us from making any differentiation about who paid more or less, and what we ended up doing is simply providing the data.

On access to care, one of our first efforts actually just looked at what were the standards that states had and how were they implemented and what did they do about them. Overall -- and I suspect this is just a construct of regulations -- we found that states did more focus and more standardization of managed care than of anything else. Fee for service was relatively unregulated, and there were not standards that were -- there may be standards in place, but they weren't necessarily reviewed or acted on. And where states did make pretty consistent efforts, however, was in monitoring children's use of services.

Finally, I wouldn't be GAO if I didn't mention that Medicaid has been on the high-risk list for concerns about the cost and the diversity of the programs make it

oversight challenging and oversight difficult. We also have published, primarily through my colleague Katherine Iritani, who is in the Seattle office and likely to be joining you in the future, work that is related to supplemental payments and other financing arrangements. And there's basically, I think, two major issues or concerns that GAO tends to raise in this area.

The first is a lack of transparency. When you're not aware of what's going on, it's very difficult for CMS to see if these are calculated correctly and to see if they're done within available limits and as allowed by the statute and regulation.

Secondly, the whole issue of what does it cost to provide a service gets masked by these financing arrangements, and that creates all kinds of difficulties when you start trying to think about what does it cost to provide service. When you start looking at the graphs with 5 percent or 54 percent of the expenditures, it's tough to piece out what that actually means.

Finally, we've done some work on community health centers. This has been -- you know, one of the interesting things about GAO is that we're a bit hit or miss. We do work that we get asked to do in statute and then by request. And on community health centers, we've done some work that has looked at delivery sites and how grants have been awarded. We also spent a pretty good amount of time looking at the Prospective Payment System and the extent to which it was likely to sustain community health centers over time. We did raise some concerns about that. The medical expenditure index that's used is not growing as far as costs are growing, so over time that could become a concern.

And this is what we're doing right now. We are very close to issuing a review that looks at all 50 of the states and their expenditures in the Recovery Act. I think that will be out literally in the next one or two weeks.

My colleague Katherine Iritani is working on a mandate that looks at Medicaid and CHIP dental services, and she's also looking at primary and specialty services for children.

I have two other projects underway right now that are related to Medicaid. One has to do with parent and caretaker coverage. This is another mandate, and it's looking at the extent to which a parent's coverage has an effect on a child's coverage, access, and utilization of care. That is likely to be out this fall or this winter, somewhere in there. Statutorily it's due in February.

And then, finally, we did a report a few years back that looked at the federal matching rate and ways to adjust it during an economic downturn. Under the Recovery Act, Congress put in the statute asking us to take a look at this again. We're going to kind of test what we did last time and see what modifications or suggestions we would make.

Lastly, I love doing Medicaid research because it

is difficult. There's always a question of how broad do you go, how deep do you dig. And probably partly because of being part of GAO, I think digging deep is important. I think if you don't, you do lose the individuality of the states and some of the unusual circumstances that they're left to face as they implement this program.

The data systems, actually I don't want to sound too much like Pollyanna, but they have improved. They are better than what they used to be. So we've got a long way to go, but when I think of when I started compared to where we are now, there has been movement.

So I think I'm going to stop there and see what questions you have for either one of us. Thank you.

CHAIR ROWLAND: Well, I think we wish that all of the things you've outlined, both Rick and Carolyn, as in process or completed so we could take advantage of them, but I know we look forward to working with you and to seeing the results of your endeavors.

I'll open it up now to Commission members' questions. Mark.

COMMISSIONER HOYT: I was wondering, any concerns about CHIP rates that are not required to be actuarially sound at the current time?

MS. YOCOM: I'll be honest, I haven't thought about that. Do you have concerns? You're the actuary, correct?

[Laughter.]

COMMISSIONER HOYT: I'm the actuary, yes. Is it the way I dress?

[Laughter.]

COMMISSIONER HOYT: You could just tell?

MS. YOCOM: I was here yesterday.

COMMISSIONER HOYT: Maybe a follow-up question, too. The different payment schemes that are sort of evolving now, ACOs, medical home models, bundled payments, even if it's not a specific checklist requirement around soundness, how does the Government satisfy themselves that they're paying appropriately for those services?

MS. YOCOM: Okay. I'll give a stab at this. I think it's an extremely difficult task, and I think the states also struggle with are they paying this appropriately. It is not easy.

In terms of, you know, basically looking at rates, you want to ensure that costs are in line, that you're paying for things that make sense, and that you can sustain that payment over time. Those are difficult to do with the data that we have. Generally, it has been cost reporting based and then audited, has been sort of the Government auditor's response to making sure payment rates are correct. The downside of that is it's pretty much after the fact.

Do you have something to add?

DR. KRONICK: Certainly you know better than I how difficult. The only kind of saving grace here is most of these arrangements are likely to be voluntary, for a while

at least, and so the rates will need to be, you know, adequate enough to attract providers and organizations, and that provides, you know, some solace on one side. You know, on the federal government side, there are always the concerns about are they too much but hopefully not a concern we need to worry a lot about in the short run. You know, in the medium run I'm sure, you know, if these organizations really grow and this becomes an important way of delivering care, obviously it will become a bigger issue.

COMMISSIONER CHAMBERS: Could I just follow up? I just wanted to follow up on that comment. From the delivery side in the CHIP program, because so much of it is delivered in the managed care format, as we have seen at least, as a CHIP provider, the delivery system seeing it as when you have a separate program that was, you know, allegedly a commercial-like program, is -- there was a willingness for quite a while to accept Medicaid-like payments, and now providers are demanding, this a commercial product, so we want to see commercial rates. And it's a question as states struggle to pay actuarially sound rates in CHIP programs, the struggle is what is this, really. Is it a publicly funded program that should have lower payment rates, or is it a commercial-like program where there's demands?

DR. KRONICK: Very crucial questions both for current business, but even more as these programs expand, 15 million more folks coming in in 2014, and the big push in many places to have Medicaid managed care offerings in the exchange. You know, there will be a great desire to try to -- I know we'll be working hard to try to make sure that as people move between Medicaid coverage and the exchange, that they don't have to change their health plans, change their physicians, and there will be a big desire to have Medicaid plans in the exchange, which will heighten these questions of how much will providers be paid for people who are now perhaps in the exchange and not in the Medicaid side of the world.

COMMISSIONER HOYT: I didn't really respond to Carolyn's question, but do I have any concerns? I'm sure I'm not the first person to say this out loud, but the concern that was expressed, of course, was there's a higher match rate for CHIP programs, and if those rates are not subject to actuarial soundness and you have states under incredible fiscal duress right now and extremely difficult MCO negotiations around Medicaid, then the suspicion is, well, some money is kind of leaking out the back side in the CHIP program because they don't have to file any certification letter or anything else about that, and the money is not quite as dear there with a higher match rate. So maybe that's a way to make things better.

MS. YOCOM: Yes, and CHIP has sort of two-edged sword. On the good side, it's primarily children, which is -- you know, that's a cost that's quantifiable and in terms of health care overall relatively cheap. On the other side, however, it's a pretty small population, and that's where

the negotiations, I think, can be difficult with the managed care organizations because they can be looking for volume as a means of getting a negotiable rate.

Another thing I was going to mention is that, you know, the states are also going to be introducing a new population that they haven't necessarily covered. Some states have and may be able to inform and advise other states. But there's two ways of thinking about the population that's going to be added into the Medicaid program. One is that there will be pent-up demand. The other is that this is a relatively healthy population that may not need much. And, you know, I think it depends.

COMMISSIONER CHAMBERS: Carolyn, you mentioned the issues related to children that the GAO is looking into, and some of those as mandates and some of those as part and parcel of the larger Medicaid issue. And I realize that Karen has primary responsibility for most of those pediatric issues, but could you share with the Commission some lessons learned and some observations specific to your findings with regard to Medicaid and CHIP services for children?

MS. YOCOM: Boy, that's a tall order. Are you thinking in terms of access, in terms of -- help me a little bit.

COMMISSIONER CHAMBERS: Well, if we take a look at the citations you have in your presentation about children's coverage, there are two -- at least two; there have been more than two in recent GAO studies that relate to Medicaid and children's dental services. But more broadly there has also been the study with regard to specialty services and also now the one that you're engaged with on the relationship between parents receiving care and kids' care.

MS. YOCOM: Yes, okay. Thank you. That helps.

With regard to children's coverage, I think a couple of things. One, there's a lot of things that have to be taken into account when you take a look at a child's receipt of services and reasons why or why not they aren't getting in to a doctor. Certainly the research shows that children who are insured generally have better access to services. Then when you start looking at how often they use those services, there's a lot of correction that needs to take place when you're looking at poverty and income levels and other ways to adjust the data.

Once these data are adjusted, the research is pretty varied. In some cases it's found that Medicaid and CHIP are comparable to private insurance on particular aspects; in other cases it has really shown that there's more to be done when serving low-income populations.

Katherine's work on dental I think does a good job of outlining a lot of the complexities of providing especially dental services to a low-income population. And you have behavioral issues in terms of getting people to the doctor, in terms of being able to keep an appointment, and in terms of being able to get to an appointment. And then you have other issues in terms of cross-culture, in terms of

communication and follow-up that come into play as well. It's not an easy problem.

CHAIR ROWLAND: Rick, we've had a lot of discussion here about program data, especially with Cindy and Penny at the last session and our discussion yesterday. But we haven't talked as much about how that might be linked with or combined with more survey research. And knowing your past experience as a researcher in dealing with these large national databases, can you enlighten us about any chances that those databases will be enriched and more timely perhaps for us in our deliberations?

DR. KRONICK: Well, as you probably know -- and I imagine Cindy discussed -- there has been a tremendous investment in the MAX data as part of the CER investment that the administration has made, and so the MAX data is scheduled to be greatly accelerated in its timeliness and in its utility as it gets linked with, as I mentioned earlier, death index data and other survey data sources. So there's work going on to link MAX data with the American Community Survey and for the first time to be able to understand something about the functional status of Medicaid beneficiaries across the country and across settings.

So there is a lot of energy there, as I can imagine -- I missed Cindy's presentation, I'm afraid, but Cindy will likely discuss the efforts to improve the availability of data for the many beneficiaries who are in managed care, which is, of course, a big hole in our current understanding of the world, and we're working hard to try to improve that.

CHAIR ROWLAND: Great. Did you have another follow-up question?

[No response.]

CHAIR ROWLAND: Well, then I want to thank both of you for joining us, and we appreciate the efforts you and your colleagues are pursuing. We know we will benefit greatly from the projects you already have underway, and we look forward to continuing to meet with you and to have you part of our deliberations. So thank you for being here.

DR. KRONICK: It's a great pleasure. We look forward to working together.

CHAIR ROWLAND: And with that, we will adjourn our first official public meeting of the Medicaid and CHIP Payment and Access Commission unless there is anyone who wants to offer public comment.

[No response.]

CHAIR ROWLAND: No one signed up. Thank you very much for attending.

[Whereupon, at 11:24 a.m., the Commission Meeting was concluded.]