Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

The Ballroom
The Fairfax at Embassy Row Hotel
2100 Massachusetts Ave., N.W.
Washington, D.C. 20008

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12:38 p.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
HERMAN GRAY, MD, MBA
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
ROBIN SMITH
STEVEN WALDREN, MD, MS

LU ZAWISTOWICH, ScD, Executive Director

DAY ONE AGENDA PAGE

P R O C E E D I N G S [12:38 p.m.]

CHAIR ROWLAND: Good afternoon, everyone, and welcome to this meeting of the Medicaid and CHIP Payment and Access Commission, MACPAC. We're pleased to have you joining us this afternoon for our discussion where we're going to try to focus on getting some additional background for the Commission members on some of the key issues and challenges facing the Medicaid and CHIP programs, especially focusing on access issues and beginning some of our discussion of payment and provider participation issues as well as models of care.

Our first panel today is on Access to Care and the Development of the Early Warning System, and for that panel we've asked Jenny Kenney, our senior advisor on research, to be the panel lead-off speaker and to key up our discussion on this issue. So I will turn over the mic to Jenny, and she has the computer in front of her ready to begin her discussion. The Commission members should all have in their packet, in their yellow packets, the slides that will be up on the screen if they want to follow along with the slide presentation.

Thank you, Jenny.

ACCESS TO CARE AND DEVELOPMENT

OF THE EARLY WARNING SYSTEM

* DR. KENNEY: Thank you, Diane. I'm delighted to be back and continue the discussion that began in September where a number of issues of relevance to the Commission were highlighted with respect to access to care.

Today I'm going to focus on providing background information and a framework for discussing access issues that pertain specifically to children covered on the program and highlight some of the key findings that came from an expert roundtable that we hosted, that MACPAC hosted back in September. And this is leading toward our December presentation at which we'll present new data on access to care for children in Medicaid and CHIP, focusing on what we have available at a national level, and identify a number of areas where we have gaps in the data available to support a comprehensive assessment of access, both at the national and state level, and identify some of the policy questions of importance for considering access to issues for children.

First, the starting point is that Medicaid and CHIP are an incredibly important source of coverage for children in this country. According to data from 2008, on

any given day over 25 million children relied on Medicaid or CHIP for coverage as their primary source of coverage, and even larger numbers relied on that coverage at some point over the course of the year.

Importantly, Medicaid and CHIP enrollment has grown substantially and have come to play a much bigger role in providing coverage for children over the last 20 years. It's a consequence of both expansions in Medicaid eligibility that began back in the 1980s; it's a consequence of the creation of CHIP in 1997; and it's also a result of what are intense investments in outreach, in enrollment, and retention efforts across the country.

As a consequence, the public coverage increases for children have more than offset what has been a steady drip-drip erosion of employer-sponsored coverage in this country, and really remarkably, at a point of recession, the uninsurance rate among children reached its lowest point in over 20 years, according to data that the Census Bureau has been collecting; and at the same time, the coverage experience of children is in sharp contrast to what we've seen happen for adults where the uninsurance rate has been rising.

When we think about these two programs, it's critical to keep in mind how much larger Medicaid is in terms of its reach. It covers about four to five times as many children as CHIP, and it's important to keep in mind how much these programs now offer potential safety net coverage to families whose incomes are above the poverty threshold but may still put them at risk for not having access to employer coverage. As of earlier this year, all but four states have eligibility thresholds for children at 200 percent of the federal poverty level or above and fully 18 are covering children with family incomes at 300 percent of the federal poverty level or above. And that's a consequence of what has been identified as a growing uninsurance problem among these more middle-income families.

There's tremendous variation across the country in the programs that exist for children. In CHIP, about two-thirds of the programs use a separate non-Medicaid program for some or all of its coverage of children, and while there's not nearly as much variation in benefits and cost sharing for children as we see for adults in Medicaid, there are differences especially between Medicaid and CHIP along those dimensions; and there are important differences in

service delivery arrangements, reliance on managed care and provider payment approaches and levels.

A cornerstone of Medicaid for children is a benefit package and a cost-sharing structure that's explicitly designed to meet the developmental needs of children, and the medical necessity definition is different than what's typically used in commercial coverage to emphasize not just repair related to injury or illness but services that promote positive development.

While states had latitude in their CHIP programs over a number of aspects of their benefit and cost-sharing structures, most states have chosen benefits and cost-sharing structures that put them much closer to Medicaid than to commercial coverage. But provider payment and administrative barriers related to paperwork, prior authorization requirements, payment delays have been documented to limit provider participation, especially when compared to what children with commercial coverage can potentially receive. And the studies that have been done point to more pronounced participation gaps and referral problems in certain specialties, like psychiatry and some surgical specialties, and among dentists as well.

The Medicaid and CHIP programs cover very large shares of children who are below the federal poverty level and a good chunk of children who are near the poverty level, as those families tend not to have access to affordable employer coverage.

Despite their low incomes, though, 75 percent of the children who are covered under one of these two programs live in a family with one or more employed adults. Over 40 percent live in single-parent households, and both the employment situation and the family structure raise concerns about families' abilities to take advantage of services that are available, if they're during normal working hours, and so there's some contextual factors that need to be kept in mind when we think about access that relate to the characteristics of the populations served.

There are literacy questions as most of their parents have not completed high school or have just a GED or high school degree. Over half of the population of children served by Medicaid or CHIP are either African American or Hispanic, and high numbers have special health care needs.

When we step back and slice the question the other way and ask how dominant is Medicaid and CHIP in serving

different kinds of children, the first thing is about one in three children at any point in time depend on these programs, so it's a big player. It's an important source of coverage for children. But even more important, I think, for us to recognize is that over half, close to 60 percent of all the children who are classified by their parents as being in fair or poor health, or close to half of those with an activity limitation are served by Medicaid or CHIP. So the ability to reach and improve the lives of children with chronic health care problems is extremely large given the reach of Medicaid and CHIP. Medicaid and CHIP cover a very large share of kids with low incomes, almost half, 46 percent, of Hispanic children and 48 percent of black children; and at such a critical point in a child's life, 41 percent of all births, according to recent Kaiser estimates were financed by Medicaid. So Medicaid is not a bit player in the lives of our nation's children and certainly has potentially profound impacts on some of our most vulnerable children.

So this is as context for thinking about monitoring access for children in Medicaid and CHIP. First, when we compare access for children in Medicaid and CHIP to

children who are covered by other payers, it's absolutely critical to take into account the very different characteristics of the children who are targeted by these programs in terms of their race and ethnicity, their incomes, their health status, their family circumstance, because all those factors shape need for care and demand for care and need to be understood when interpreting those patterns.

Likewise, there are important differences across states in the characteristics of the children served because of the income thresholds that have been chosen and because of the characteristics of the children in those states.

Looking and understanding how access is operating for children at a national level is essential, but really doesn't give us all the information we need given how different the programs are across the country, and so a state-level access monitoring is critical.

Given the research that has been done and the very different payment and provider participation questions and needs of the populations served by Medicaid and CHIP, it's absolutely essential that access be looked at not just generally but by specialty area and by type of service if

we're really going to understand what's going on. Importantly for children, given the developmental, the key role -- the key changes that they're experiencing throughout childhood, it's critical that the access monitoring reflect those developmental needs and target kids of different ages. And then the role that socioeconomic status and race and ethnicity play in access needs to be better understood, needs to be addressed when making access comparisons. But it also is a factor in assessing the way the programs are delivering services, whether they're addressing some of the unique aspects and needs of these populations in terms of language barriers, transportation barriers, housing issues -- all the other factors that shape a child's well-being and may interfere with their healthy development and successful outcomes from any medical care intervention.

So what's coming next. In December, we'll be identifying themes on a number of different topics that emerge both from the literature and from the new analysis that we're doing. In terms of key questions, we'll be reinforcing some of the themes that have already been presented in terms of access patterns for primary care as opposed to specialty care, and really trying to get a handle

on what we know about what the policy levers are that affect access and, importantly, what we don't know and what we need to know more about.

We'll be trying to raise a number of questions regarding limitations of existing measures for tracking access and the surveys and administrative data systems to support those measures. As I said, we'll be putting together a national profile on access to care for children in Medicaid and CHIP based on what we can do with existing data. We'll be hosting an expert roundtable on access issues for children, and we expect to have focused attention on dental access and some of the core issues around the Early Periodic Screening, Diagnosis, and Treatment benefit, which is the core benefit for children but doesn't always function the way it was designed. And at the same time, we'll be developing and presenting for your review a longer-term work plan that identifies priority areas for additional research and analysis and that identifies both qualitative and quantitative research methods that would be associated with addressing those goals.

As I said, in September we had an expert roundtable on access to care, drawing researchers from

around the country, and I just want to share some of the highlights that came from that meeting.

The sense of the group was that a meaningful monitoring on access requires focusing on both outcome and process measures, that you really can't interpret one without the other, and that you need to be doing both.

Likewise, there were strengths and weaknesses noted with both administrative data systems and with surveys for telling us meaningful information about access, and so it was felt that you really needed to build a system that leaned on both data sources.

There was a lot of discussion around some of the complexity involved with understanding what's going on through administrative data systems around managed care -- and you're going to be hearing more about that later this afternoon -- and some of the questions that really are outstanding around managed care versus fee for service and different types of managed care in terms of carveouts and PCCM.

There was a sense that safety net providers are a critical source of information about what's going on in local communities in terms of access and that information on

demand for safety net services, or services from safety net providers like community health centers, but also issues that they're facing in terms of referrals for the patients who are coming through their doors could be a really important and vital complement to some of the more quantitative assessments that would be done in terms of monitoring access.

Many of the researchers felt that it was absolutely essential to take account of the very important socioeconomic and social factors affecting access, and one that was raised was geographic location and the potential mismatch between where many of the children who are eligible and covered by Medicaid live and where the providers live, especially the private practice providers.

It was recommended that both long- and short-term strategies be developed to evaluate access, that the short-term real-time analyses were critical but they needed to be supported by longer-term careful data analyses, that the two together were an appropriate approach. And I think there was a sense of frustration that we don't have better guidance from the research that has been done on the impacts of particular policy choices that states are making on

access to care and on efficiency of service delivery and effectiveness of that care; and that the early-warning system that Lois Simon is going to be discussing in a moment, that it needed to rely on multiple data sources and indicators, and that it needed to build in a flexibility to respond to changes in information; and that there was no existing set of information that could easily be tapped for this. And so it was important to consider a variety of data collection strategies to put this together.

With that, let me turn to Lois so she can talk more about the early-warning system.

CHAIR ROWLAND: This is Lois Simon, principal policy analyst for MACPAC.

* MS. SIMON: Excellent. Thank you. Hi. I'm here to give you an overview of our proposed work plan for an early-warning system.

As you know, MACPAC is required to develop an early-warning system. As is written in statute, the early-warning system should identify provider shortage areas as well as factors that adversely affect or have the potential to adversely affect access to care or the health status of Medicaid and CHIP beneficiaries.

To be effective, we need to develop an early-warning system that can detect access issues in a timely manner, that uses data that are obtainable and valid, and that takes into account all the right elements needed to trigger a potential problem. So to do this, we have developed a proposed work plan that has three main components, each of which I will briefly highlight for you today, and I look forward to your input on this work plan design.

The first component is to understand what states are currently doing with regards to measuring access to care. A catalog of the different types of measures being used by states will be compiled from state surveys, the published literature, as well as discussions with a number of states.

Once the catalog is complete, we will use it to determine, first, which measures are well covered in state systems, where are the gaps, how is access measured for managed care as well as for fee for service; and then we'll use our discussions with the states to help us understand what state strategies are for measuring the access. So what are they using the data for? They collect it, and how are

they using it?

The project will also explore the feasibility of incorporating specific key measures into the early-warning system. So also in addition to what is catalogued, other tracking opportunities will be addressed, and one thing that we're excited about is -- or thinking that is going to give us a lot of information is looking at complaints or calls that come into state and plan hotlines, and also looking at consumer ombudsman programs and kind of getting a grasp before it comes in there.

So it is important for us to also know whether states will have the ability to carry out the specified steps needed to support an early-warning system. Again, for a system to be successful, what goes into it must be doable for the states or for those who collect and track the data.

So to do this, we will dig deeper, and we will examine practical issues, such as data collection frequency, ability of data systems to report the information with limited state burden, and issues related to comparability across states.

For it to work, an early-warning system must also be able to flag actual and potential access problems as

quickly as possible. The second piece in the work plan will take a look at public health surveillance systems, which are designed to catch public health problems hopefully before or during the onset of an outbreak. Public health surveillance systems have been around for years to provide an ongoing and systemic assessment of the health of the community. They collect and interpret and use health data to first identify an issue and then estimate its magnitude. And then the systems also monitor change as well as drill down to the specifics such as geographic area and specific populations. And then, lastly, these systems use the information gathered to help inform policy.

So what can be learned from today's public health surveillance systems and what mechanisms can be incorporated into our early-warning system will be the focus of this second component.

The third piece of the work plan is more conceptual: identifying the questions that need to be asked in order to develop an early-warning system framework. It is important to get it right and to consider all issues. So a broad range of measures or indicators will be reviewed. There are the current access to health care measures, many

of which will be identified in the catalog of measures that will be developed in component one, but we also want to look at an array of other types of indicators and try to understand their usefulness in an early-warning system framework. Examples are economic indicators such as unemployment rates, state policy variables such as the relationship of payment policies to provider supply, and then changes in health system delivery and workforce. So the impact of hospital closures and increased use of safety nets or ER use and availability of specialists as just a few examples.

So we will look at each of these indicators and ask whether and how they could be used in an early-warning system. Among other things, we'll look at how they are collected, the frequency with which they are collected, and the included population.

We also want to be able to hammer in on what indicators could identify pressure points or problems quickly, also what kind of combination of indicators are needed to predict access issues both in the short term as well as in the future; and then once a problem is triggered, what and how much intensive monitoring is required; and also

look at whether or not geographic -- how to drill down to specific geographic areas, and if so, when would we do that.

So there are a lot of questions to be raised, and this effort requires a thoughtful and thorough review of many, many important issues.

So after this exercise, the next steps would be to really identify the specific components of an early-warning system and then figure out how to operationalize a system that fits in the current Medicaid and CHIP world.

At December's meeting, we will come back to you with progress in each of the areas, but I look forward today to your input on the work plan and as we move forward with designing an effective system.

Now I'm going to turn it over to Michael Nardone, who is going to give us kind of a highlight of Pennsylvania's experiences with measuring access to care.

* MR. NARDONE: Thank you very much. My name is Michael Nardone. I am the Acting Secretary of the Pennsylvania Department of Public Welfare. Up until several weeks ago -- it has been a whirlwind several weeks -- I was the Medicaid Director for Pennsylvania, and I want to thank you for having me here today and to give the State

perspective on some of these access issues that we're talking about, specifically how we monitor this.

I also want to thank you for giving me the opportunity to drive down Route 15 through the Maryland mountains. It was quite a beautiful drive.

When we talk about access, I think we really focus on a couple of key things, both in our managed care and our primary care -- enhanced primary care case management model, and I'm going to talk and touch on these today. We look at issues around network adequacy. We also drill down with respect to not only is the network adequate, but are people actually getting into the appointments that they need. We also look at both nationally recognized measures as well as some Pennsylvania-specific measures around access, analysis of data around HEDIS measures, CAHPS measures, around whether or not individuals are actually having encounters with various physicians or dentists. And then we also drill down further, because it's not just about whether or not someone actually has an encounter with their physician or primary care provider, but it's also about what is the quality of that encounter and what actually -- what services are actually delivered during that encounter.

We, just to give you a brief highlight, we have about 2.2 million individuals who are in medical assistance. We have in the urban areas of our State a mandatory managed care model, so all individuals in these areas have to enroll in managed care. We also have an enhanced primary care case management in some of our more rural areas.

The HealthChoices program, which I'll refer to because I can't help but refer to it as HealthChoices, is our mandatory managed care program. It operates in 25 counties. We have seven MCOs. And access to care is a critical component of the MCO contracts.

We also have another area of the State, which is the more rural areas, and we do have voluntary managed care enrollment in some of those counties, as well, but the principal service delivery system that we have in these counties is really our ACCESS Plus program, which is a primary care case management and disease management program that operates in 42 counties of the State. We contract with a vendor to provide those services to consumers. And again, there are access to care requirements that are included in the vendor contract.

Here's a map of Pennsylvania, just to give you a

sense of what the various counties for managed care versus ACCESS Plus. The southwest and southeast are the mandatory managed care counties and we have about 1.2 million people in mandatory managed care in the counties around Allegheny, Philadelphia, and then further west towards Cumberland and Perry County there. Dauphin County is where the State capital is. And then the rest of the State, the "T" of Pennsylvania is some of our more rural areas. If you're not familiar with Pennsylvania, one of the things I like to quote is that we actually have more rural individuals in Pennsylvania than any other State in the nation. And if you get outside of Harrisburg, if you get outside of Philadelphia, Allegheny, you quickly get into very rural areas. So obviously the programs vary depending on areas.

So first of all, a network adequacy. This is on the HealthChoices program, our mandatory managed care. We have built into those contracts a series of requirements that the MCOs have to fulfill with respect to the network adequacy for various primary care as well as specialists and hospitals. So, for instance, with respect to primary care providers, there have to be at least two open panels within the time limits that are set in the contract, and at the

bottom of the chart, you see that the time limits are 30 minutes in urban areas and 60 minutes in rural areas. We also have other requirements, but these are some of the key ones that we have in the managed care contracts.

We also have a set of appointment standards that are built into the contract, so how quickly do people actually get appointments. And we have specific requirements related to PCPs for pregnant women, for children, for EPSDT visits, as well as some of the more special care, like for individuals with HIV/AIDS. So an example -- I provide an example of what the appointment standards for PCPs might look like related to immediate access to a PCP for emergency care, urgent care appointments, how quickly do individuals get routine appointments, as well as general physical exams.

In terms of -- okay, we have the contract standards. We have the appointment standards. Well, now how do we actually monitor that? What do we have in place to actually monitor that? And in order to do that, we really rely on core teams who are within our managed care program. They are responsible for actually managing what's happening on the ground with the various managed care teams.

So in terms of their efforts, they really will rely on a set of tools in order to try to ensure the MCOs are meeting those standards. Those would include geomapping. It would include monitoring consumer complaints, as well as grievances that are filed against managed care organizations. And basically, they will do quarterly reports that compare the various managed care organizations with respect to various indicators to see if there is a problem with a particular plan.

We also identify certain focus areas for review, and so a good example of this is related to strategies for monitoring MCO performance around dental access. So basically what the core teams do is to really dig deeper around particular areas of care.

So in this instance, they would require reports and look at data around things like average distance from members' residence to available dentists, average days from appointment request to appointment date, number of cancellations, inquiries related to dental issues and access, dental visits related to ER utilization. So those are the types of things where a particular issue area has been identified and a focus is put on that specific area.

Another area would be access to maternity care.

We also use the CAHPS in terms of our evaluation of health plans, and we also build into our monthly monitoring basically a review of what hospitals and health systems have contracts that are due to expire in the upcoming period and what does that potentially mean in terms of access.

So, for instance, recently we had a major hospital system in one of our suburban counties that was up for renewal and they were having some problems with renewing their contract, and that was going to have a major access issue for people in that particular county. So one of the things that we did is we really got involved and kept kind of an eye on whether or not that contract actually came to fruition to ensure access in that particular county.

We also use extensive use of the HEDIS measures in terms of measuring access. Those of you who are familiar with our Pennsylvania program with HealthChoices, we have a very extensive pay-for-performance framework. The framework -- there are several areas of the P4P that are specifically devoted to access measures, so access measures around adolescent well child visits, measures around maternity

care, ER utilization to get the other side of that. If people aren't getting into primary care doctors, what's happening with ER utilization, as well as, as I mentioned, some of the measures around pregnancy. We are also adding into this a measure specifically targeted at dental access for children.

We also have performance improvement projects that, again, these are specific areas where the plans have to identify what steps are they going to take to improve areas of deficiency where they can improve. Again, dental and maternity care have been the two primary areas around this, as well as behavioral health and issues around racial disparities.

And then we kind of have -- so we have kind of the carrots of the P4P and then we have the sticks, and the sticks are some of the corrective action plans as well as the ability to actually assess penalties if the plans do not meet the standards that are in the contract.

A couple of things I would also highlight around the access to care measure is we use the HEDIS measures. We over-sample on the HEDIS measures so we can drill down on racial disparity issues. So even though it's not built into

the pay-for-performance measures that we assess the plans on, we look at a number of measures to see where are there racial disparities that might be impacting performance on particular measures, and that is again something that we are in constant communication with the plans and have regular meetings around how are they -- what steps are they taking to address those concerns.

So, for instance, one of our measures around access to prenatal care showed a significant difference between access to care for non-white versus white individuals, Caucasians, who were receiving services under the managed care, and so one of the things in doing their performance improvement projects would be how are you going to address those disparities? What are some of the ideas that you have for addressing those disparities?

And we also share ideas among the plans. So if particular plans are having success with dealing with a particular issue around access, we share that with the other plans so they can also take advantage of the lessons learned.

The other thing is this information is available to our consumers. So we make available a report that really

lists out for them how are the different plans doing on our access measures -- on a wide variety of measures, including access. And the guide is actually something that's online. It's something that consumers receive if they're picking plans. It's also something that the consumers themselves had input into actually how the consumer report is put together.

With respect to the other side of the house, which is the ACCESS Plus side, the enhanced primary care case management model, we similarly have network adequacy standards as well as appointment standards. Generally, you see these are more rural areas, so the time frames in terms of adequacy is a little bit longer, but that's owing to the fact of the dispersion of providers. And they are also appointment standards that are very similar to what we have in the managed care area.

And one of the things we have been doing over time is really bringing -- the two programs kind of evolved separately, but now we're kind of bringing the measures together. So we're basically measuring both the ACCESS Plus program as well as HealthChoices with the same measures.

In terms of how do we monitor in the ACCESS Plus

area, again, we use similar tools. This time, what we're doing is we're holding the vendor who does the primary care case management responsible on a number of different areas and we review monthly reports around geomapping in terms of PCPs and other providers. We monitor PCP selection by individuals to ensure that linkages get made with respect to primary care providers. And we also follow up when a person who has been referred to a PCP doesn't have a claim or an appointment in the system to ensure that they're actually hooking up with their primary care provider. We also are beginning analyses of specific populations where there may be barriers to PCP selection. And we also, the vendor is also responsible for provider recruitment efforts with respect to particular populations.

Again, we also monitor providers closely to see what is the quality of the visit that actually happens when they go in for a visit. And we also have the same sorts of incentives on the ACCESS Plus side with respect to the vendor. We hold the vendor responsible for the same HEDIS measures that we hold the managed care entities responsible for, and there are potential incentives available for that. And we also have provider P4P to help with some of our

access issues.

We have seen some good results from some of our access related initiatives and so I'm showing you, with respect to HealthChoices, some of the areas where we have seen improvement over the five years that we've been doing the pay-for-performance program, and frequency of prenatal care as well as adolescent well care visits are some of the areas where we've seen significant increases, statistically significant increases.

Access related outcomes, we also monitor them on the ACCESS Plus side, and this is just one variable that we hold the vendor accountable for around well child visits. And again, this is using a HEDIS-like measure where we're basically pulling claims data from the fee-for-service system and then overlaying that with the same rules that HEDIS uses to get a similar measure so that we can measure across programs.

Here's an area where there's a lot of effort and where, you know, we haven't been historically doing well, around dental visits. And again, one of the things that we do -- we don't only monitor those things that we do well on. We also monitor places where we have a lot of room for

improvement, and this is one of those areas. I'm pleased to say that we have kind of gotten over the 50th percentile this year with some of our efforts around dental services in the HealthChoices area, but obviously we have a lot more efforts to go.

So in terms of some of the things that we are continuing to look at to improve access, you know, one of the things when you're using the HEDIS data or the CAHPS, it's old, and so one of the things we've been working hard to do is to integrate more real-time data, more real-time claims data, and that has its challenges, you know, lags in availability of claims data, certain anomalies that might be appearing in the data that you don't know until you really drill down into it. And we have this data both for the fee-for-service system as well as encounters from our managed care providers. So one of the things that we've been aggressively moving to is how can we better integrate this real-time data into our normal processes.

We have to have continued efforts to do outreach on specific provider groups. Again, there are places where we have shortages in terms of dentists in some of our more rural counties. But again, we place a lot of accountability

on both the managed care entities as well as the ACCESS Plus vendor to help with those outreach efforts.

And then we also have begun exploration of other options for improving access, specifically one of the things we've implemented in the last couple of years relates to telemedicine. So one of the things we have opened up is codes that allow for telephonic consultations or telemedicine consultations for complex pregnancies, so the ability to actually do that with OB specialists in some of the rural counties. And then we also have done that with child psychiatrists, particularly for consults around psychopharmacology, trying to look at other ways to deal with access given some of the barriers we see in terms of workforce supply. And obviously, the explosion of HIT that we'll see in the next few years will have an impact on our ability to do an even better job of improving access.

So those are my remarks and I appreciate the ability, again, to come before you today.

CHAIR ROWLAND: Thank you all three, Mike, Jenny, and Lois, and are there questions, issues that the panelists want to raise? Donna?

COMMISSIONER CHECKETT: Thank you so much for your

comments, everyone. Mike, I was interested in what results you're having at this point with your P4P program. That was kind of the buzz a few years ago, not just with Pennsylvania, but nationally. I'm wondering what your experience has been so far.

MR. NARDONE: Well, I think our experience has been very positive, and I think some of the things that -- some of the results that we're reporting in this little PowerPoint, those are P4P measures, and I believe on nine of the 11 measures that we've identified for P4P, we've seen statistically significant increases over that time period. So I think it's been very successful.

I think one of the things that I didn't mention in my remarks, but I think in thinking about it I'd be remiss if I didn't mention it, is that it's been very difficult to maintain that program in a difficult fiscal environment. So at the legislative level, the pay-for-performance is looked at as an add-on, and in these difficult fiscal times, it's difficult to justify that. So there was one year where P4P was eliminated, and then we were able to get it restored, but it's restored at a lower level. So it is a continuing discussion with the legislature.

You know, one of the things, too, in discussing issues around State funding is that we -- at the Department of Public Welfare, there has been a pretty steep decrease in number of staff at the Department. So when I came into DPW and I trumpeted the fact that -- I was Executive Deputy Secretary at the time and I trumpeted the fact that I was Executive Deputy Secretary for a department that had 20,000 employees. Well, now I have to change my resume because it's down to about 17,000. And I think one of the issues, though, is that the State infrastructure needs to be maintained. I think we're fortunate in Pennsylvania because we have a long history of doing the quality reviews, but it is difficult to keep the staff and to keep the resources to continue with those efforts.

COMMISSIONER CHECKETT: Thank you.

CHAIR ROWLAND: Mike, would you comment on what kind of staff and what level of staffing, the administrative costs of doing and monitoring that you're doing, or how you put that together, because obviously we want the information, we want the data, but we also know these are tough fiscal times and staffing is short.

MR. NARDONE: Well, we do -- I mean, we have -- we

use a mix of both State staff as well as contract staff to do our monitoring work. We rely a lot on our contractors, obviously, to do that, whether or not it's the ACCESS Plus or for HealthChoices, and it's a fairly robust effort. I could get you specifics around what our quality unit looks like. It's led by our Medical Director and it's fairly senior-level staff who are, I think it's a unit of maybe about ten with respect to managed care. But I'd like to get you those numbers because I don't have them off the top of my head. But to say it is a fairly senior position within the Department.

CHAIR ROWLAND: That would be helpful. Thank you. David?

VICE CHAIR SUNDWALL: Just a comment. I want to thank you for your presentations. It's of great interest to me. You may not know or may not readily think of an ally in this, but it's the State Health Officers. We just had our annual meeting of ASTHO, the State and Territorial Health Officers. An access committee was one of the most vital and vibrant and of interest to that group. Various ways of measuring access in States from a public health perspective, but the consensus, of course, is that health status is

dependent in part on health insurance coverage. So it's a factor that we are keen to see broadened, and so it certainly relates to this Commission.

Also, you need -- I mean, I'm sure you are aware that HRSA is now underway in reevaluating how they determine shortage areas. They have a negotiated rulemaking process in place where they're revisiting how do you determine a health profession shortage area or a medically underserved area. There are very antiquated tools. Believe it or not, if you are an MUA, a medically underserved area, that's for life. I mean, that's as silly a saying you can imagine, because, of course, the demography has changed. So we need to collaborate with them -- they're real allies -- and as we do our report, to make it current and up to date with the new methods they're going to use to measure access.

But States have their own various ways. We have in Utah mapped our safety net providers and can tell you where they are and who they are. So we need to, as we're already planning to do, survey States and see how do they do it and how do you monitor this.

CHAIR ROWLAND: Herman?

COMMISSIONER GRAY: I have a couple questions

about children with special care needs. Jenny, you pointed out that roughly half of kids with chronic conditions or special health needs are covered by Medicaid or CHIP, and I know we're going to hear more about this in November, but can you give a sense of how big the challenge is in terms of what we do know about access for these special need populations? Most of the population has been about primary care. Either federally or at the State level.

Second question, I'm curious in terms of the Pennsylvania perspective that uses a large number of managed care organizations, how well suited are these managed care organizations to provide care for children with special health care needs and do you have any data on access to subspecialists? You have at least two great children's hospitals in Pennsylvania. Any idea of what access is like for those populations? HEDIS measures, CAHPS, those kinds of things don't really get at that population.

DR. KENNEY: Probably it wasn't worth taking a mic to respond this way. I think we'll be able to speak very broadly to access to specialty care and to look at that for children who have special health care needs or chronic health care problems. But I don't think we have the

national data and I certainly don't think we have it at the State level to tell us for kids with different kinds of problems and different kinds of needs what kind of specialty access problems they're experiencing specifically. But we will be able to speak to the magnitude of the general problem and then pull together bits and pieces of information about specific specialty areas. But I think it's a real hole in what we know. And that's not only for Medicaid and CHIP, but more broadly for kids.

COMMISSIONER ROGERS: Jenny, will you be also looking at the behavioral health needs of children? We see more and more children being diagnosed with behavioral health issues.

DR. KENNEY: We absolutely will be looking at the subset of children who are identified as having those needs, but I think you'll be frustrated by what we know about the extent to which those needs are being met. But we're going to put together as rich a profile as we can. We recognize that's a really important question. But I think it may be one where we conclude that we're not necessarily asking the right questions or asking them about this particularly vulnerable group of needy children.

CHAIR ROWLAND: It may also be one in which, while we don't have national data, we could drill down and have a State that might cooperate with us in providing their data, which gets us back to letting Mike answer the question.

[Laughter.]

MR. NARDONE: Always happy to help. In terms of the ability of MCOs to handle individuals with special needs, particularly children, each one of the plans has special needs units that are responsible for the provision of care for particularly complex individuals in terms of -- including children. We also have developed an intensive case management unit centrally that basically handles some of the more hard-to-serve children and adults. The role of the intensive case management is often to deal with issues that are not necessarily medical issues, maybe issues around transportation, housing, things that kind of interact with the health needs of individuals.

In fairness, I think I would say that some of the plans do a better job of providing services to children with special needs than other plans. We do have provisions in the contract that require the availability of specialist care. I was just kind of looking at that. Basically, you

have to have -- individuals with special needs have to have two specialists or subspecialists available to them within the zone, and if they don't, they have to allow an out-of-network provider to provide those services.

And we also have built into the contracts provisions that for those plans that provide a high percentage of home nursing, because frequently that's one of the costs involved, they actually -- that we have basically a risk pool for home nursing costs so that those plans that provide more home nursing get a larger share of this pool to ensure that they're not at a disadvantage in terms of other plans that maybe don't have as much home nursing, and we tend to have like two or three plans that are actually in the different zones that actually tend to provide a high amount of that care.

COMMISSIONER MOORE: Mike, can you comment on, I guess, two approaches to the same question, and you may not feel comfortable doing this, but how representative do you think Pennsylvania is in terms of your monitoring of access issues, and how much variation do you think exists between and among States in terms of monitoring access?

MR. NARDONE: I mean, I think that's a really hard

question for me to answer, but I think in Pennsylvania, we have a much longer history of managed care dating back to 1990, even before -- Health Pass in West Philadelphia. But the current HealthChoices program has been around since 1997. So that's been -- so I think we have a lot of experience with that and I wouldn't think that -- probably if we went back 13 years, we didn't have as robust an infrastructure as we do now, and in fact, the pay-for-performance was not implemented until 2005, so it was eight years until we got to that point.

So I think it's probably going to depend on the State and how much managed care do they have and also what is their experience with it. We have a fair amount of experience and have been able to develop a robust monitoring effort around that.

COMMISSIONER MOORE: Have you done it pretty much on your own, or have you taken lessons from other States or worked with other States in any way on a --

MR. NARDONE: Well, I think we definitely learn from other States. You know, the development of the primary care case management model is something that we began in 2004. A lot of that effort was educated and informed by

what other States were doing with respect to ACCESS Plus. I think that in terms of managed care, we all -- the Medicaid Directors Association has a wealth of information. I always learn new things, new tricks, as well as other efforts to share information from other States. So, I mean, we continue learning and evolving.

CHAIR ROWLAND: Trish?

COMMISSIONER RILEY: Mike, thank you all. Could I ask you just a couple questions. I am always struck with the -- the access issue is so tough. We think it's just easy to measure, and it's so complicated. But we know that one of the strategies to improve access is to increase payment, and in this budget environment in States, that's not going to happen anytime soon.

There's also the issue of providers who sometimes, I think, use that as an excuse, but, in fact, find low-income folks, Medicaid folks, difficult to deal with. They cancel appointments, they don't comply, et cetera, et cetera. You said you monitored cancellations and I'd be interested in knowing more about that.

And a second question maybe for Jenny is there are always trade-offs. You can have perfect access and crummy

outcomes. You can have perfect access to a crummy benefit. You can have perfect access for one group of people and then not afford eligibility for everybody else. In our State, we decided to cover children only to 200 percent so that we might cover their parents to 200 percent, which we do. What do we know about the impact on access to care when parents are also covered? So two questions.

MR. NARDONE: Well, I agree with you, the different components and variables related to access. And just in terms of one of the areas that we've had a great deal of effort around is around dental care. We still have a long ways to go, and it is -- we have had -- we've really tackled that problem from a number of different ways, and part of it is actually recruiting dentists to participate in the program. It's also the perceived administrative barriers that a dentist might have to participate, particularly in some of these rural areas that we're talking about.

So one of the things that we will be sure when we're outreaching to dentists is here are the -- it is an easier process to bill. It's not as hard as you think it is. You can do it online if you have the ability to do

that. I mean, kind of trying to make sure that they're aware of some of the enhancements in our system.

Part of it is understanding why individuals cancel appointments, because that's a complaint you always hear. And, you know, our MCOs and our ACCESS Plus vendor do try to -- they have initiated various strategies to try to incent individuals to actually keep their appointments.

But then, also, it is a provider payment issue. Now, we've been fortunate to be able to, in the area of dental, have some targeted fee increases over the period of the 2003 to 2010 period. We're fortunate that we haven't had to have the drastic cutbacks that other States have had to deal with. But, you know, in addition to the targeted fee increases, we've also tried to develop a pay-for-performance program for some of our dentists where basically a dentist receives a P4P -- a provider pay-for-performance payment if they do both a comprehensive dental visit as well as provide follow-up care within six months. And that is something where we are beginning to see some numbers in terms of more dentists wanting to participate in the program.

It's really early and we could easily step

backwards if what happens next round of budget when Federal FMAP, enhanced FMAP goes away. I think there's going to be incredible pressure on State budgets to be able to maintain those provider payments. But I think that's going to be something that we're going to have to continue to advocate for at our level.

In terms of the -- I don't know how to answer the second question, Trish, because I don't know that I have really good data to answer you on that. That certainly has been something that we, in terms of developing our program in Medicaid, try to make sure that the parent and children are on the same plan under the theory that that's going to be easier for the family to receive care.

Now, I don't -- in terms of we don't have a program up to 200 percent of poverty. What we have is our Medicaid program and then we have a State-funded program. And so obviously with health care reform, I think that will give us the ability to kind of merge those two together.

DR. KENNEY: Trish, I think you are raising a really critical issue for kids, and I'd say there are three documented pathways that meeting the parents' health care needs affect the children. Untreated mental illness and

depression has documented effects on children's health and well-being, and we know that parents who have coverage are more likely to receive treatment for those services. There is strong research evidence there.

Second, there's research evidence that there's a connection between participation of parents in Medicaid and the participation of their children. There seems to be -- we're not exactly sure of the pathways, but it's been demonstrated in a number of States, when they've expanded coverage to parents, they've pulled in more of the kids, as well.

And then last, and again, I'm an economist, I can't really speak to what's going on at the family level in terms of decision making and information, but it does seem that when the parents have coverage, that there are positive spillover effects on the services that the children receive. This has been documented in terms of well child visits. But I just saw a recent study that suggested when parents have a usual source for dental care, that their children are more likely to be getting dental care. So is it health literacy gets raised? Is it a familiarity with the health care system and ability to navigate those systems? I'm not sure

of the mechanisms, but they're powerful influences, and I think, as Mike indicated, health reform, one of its primary potential positive impacts on kids' lives is in increasing coverage for their parents.

CHAIR ROWLAND: Robin?

COMMISSIONER SMITH: Mike, I have a question. I'm going to give you an example at the end to back into my question. Within the managed care programs, especially for children with special needs, do they have the flexibilities in these programs to approach each child's particular needs? And what I mean by that is often you'll have a child who can only receive OT once a week, or 52 or 50 times a year. But you have a child who may be tube fed, and if you had the opportunity to work with more frequency with an OT, PT, a pediatrician, a dietician, maybe four days a week, that after two, three, four months you might have a child that the G tube could be removed. He would be eating on his own. There would be a huge cost savings to the State or to Medicaid over the long term. Do they have the flexibility to look at a situation like that -- and that's just one example -- and perhaps increase the services to that child in order to, on the back end, decrease what the child will

end up costing over the life of the child?

MR. NARDONE: Well, I mean, the way our managed care plans work is they do have the flexibility to design the service package. They have to provide the minimum benefit that's required under the fee-for-service program, so they can't provide anything less than that. But they certainly, if there is a provision of care that is potentially going to be more cost effective, they certainly have the ability to do that within their contract.

You know, the thing is that we -- I mean, the way -- we do hold the managed care companies responsible for managing the care. So we're not -- in the managed care areas, the beneficiary of cost effective care in that instance is the plans -- are the plans. So in that instance, however, we would be -- we obviously monitor. We have the special needs units at the plan levels. We also have a parallel special needs unit within managed care that basically oversees those special needs units to make sure that individuals are getting care that they need. I mean, that is basically the framework.

COMMISSIONER SMITH: How do you determine that they are getting -- I liken it to giving a child who has an

infection half of an antibiotic. You might get the prescription paid for. You might get the antibiotic. But at half-a-dose, they're never really going to get well. They're never going to see the benefits --

MR. NARDONE: I mean, well, I think that --

COMMISSIONER SMITH: -- if they had a full dose -

MR. NARDONE: -- and I think that the way we --

COMMISSIONER SMITH: How do you determine -- I'm sorry, but how do you determine it if you're overseeing that program?

MR. NARDONE: Well, I think that the framework that we -- I mean, I think there are a number of different tools that we use, so we use some of those broader tools that we're talking about around some of those performance measures. We also use the survey results that we receive. We're always monitoring complaints or issues from beneficiaries and we also monitor appeals. So if a consumer doesn't feel they're getting the appropriate level of service, there are requirements around an appeals process and that the plan has to deal with those appeals within a timely way, and if they can't, then they come up to the State. And one of the things that those core monitoring

teams will do is they will review where are complaints, where are appeals coming from.

And so there are different -- I guess I'm saying you can't rely necessarily on one thing, but I think we have a number of overlapping indicators that help us understand where there might be issues with MCOs in terms of the provision of care. So I think that's the way we try to do it from.

CHAIR ROWLAND: Okay. Well, I want to thank our panel. I think it's quite clear that as we move to looking at access, looking at the issues for special needs children will have to be front and center as one of the indicators of how well the system is performing. Clearly, developing the early warning system will require a lot of indicators. Some may already be available. Others may need to be developed.

But we especially want to thank Michael Nardone for coming down and sharing the Pennsylvania experience with us because I think that will help inform us as to where different States are and what on-the-ground experience we can look at as well as some of the literature and the research data from surveys. So thank you for joining us this morning, and thank you Jenny and Lois, and we'll call

our next panel.

Enjoy your drive back.

[Laughter.]

MR. NARDONE: Well, it's light out.

CHAIR ROWLAND: It's light out, right.

And I want to welcome our second panel. We're going to continue our discussion of access to care issues, but we're going to turn to a focus on non-elderly adults under Medicaid, and we are being joined this afternoon by Sharon Long, Senior Economist with the State Health Access Data Assistance Center, which we call SHADAC just to make it short, like call us MACPAC. And we're also joined by Jason Helgerson, the Wisconsin Medicaid Director who didn't get to have a lovely drive down from Pennsylvania but instead flew in from Wisconsin this morning, and I hear is going back early this afternoon. So we're delighted, Jason, that you made the effort to be here with us as well, but let Sharon kick off our discussion.

TAKING STOCK: ASSESSING ACCESS TO CARE FOR NON-ELDERLY ADULTS UNDER MEDICAID

* MS. LONG: Hello. I'm pleased to be here today to talk about access to care for non-elderly adults on

Medicaid, and I wanted to start first by just clarifying who non-elderly adults are since it's a little more complicated that children.

So Medicaid does cover adults in categories: pregnant women, disabled adults with SSI benefits, supplemental security income, parents and adults without dependent children living with them. And the eligibility standards do vary across the population.

And then also I'm focusing on non-elderly adults in the community, so I'm not looking at elderly adults in nursing homes or other institutionalized care. So it's again they face a different system of care, and so we're not looking at that here.

Under the Affordable Care Act, Medicaid will expand coverage to nearly all non-elderly adults with family income less than 138 percent of poverty in 2018, but currently there's wide variation across the states in terms of who's covered among non-elderly adults.

Non-elderly adults without dependent children are not typically eligible for Medicaid coverage in most states. I think only five states now cover non-elderly -- childless adults is an easier phrase -- childless adults with Medicaid

or Medicaid-like programs.

Parents and disabled adults are typically covered must less than 138 percent of poverty. For parents, the lowest state is at 17 percent; for disabled adults, the lowest state is at 56 percent of poverty.

Pregnant women are covered at higher levels, ranging from 133 percent of poverty to 300 percent of poverty.

And then children are at much higher levels, ranging from 160 percent to 400 percent of poverty, so much less generous coverage for adults than for children in the Medicaid program.

And perhaps reflecting the lack of focus on children in the program is there's much less research on non-elderly adults as well, and so we know less about access to care for that population. And the research that's there is also less likely to make adjustments for who's enrolled in Medicaid, so that we have more difficulty separating out what's the effect of Medicaid from the effect of being enrolled in Medicaid.

Then the non-elderly adults on Medicaid are much more likely to have health and disability problems. So this

slide is just summarizing some measures of health and disability across the population, comparing non-elderly adults on Medicaid with employer-sponsored insurance and the uninsured across measures of fair and poor health status -- having limitations, having a chronic condition, here looking at hypertension, diabetes and asthma, having depressed or anxious feelings all or most of the time and current smoker.

In looking down that column, you can see that Medicaid is significantly higher on all those dimensions than either those with ESI coverage or the uninsured, and in this slide the asterisks show you which are the statistically significant differences. As you can see, all of those are different.

So it's important in comparing access to care across the populations to take into consideration that there is significant differences in their health care needs. The gold standard here would be to do random assignment experiments, assigning people to insurance status, and clearly that's not feasible. So it's important to realize that all the studies that do exist have some methodological limitations.

So we have to kind of interpret the findings with

some caution, and the key piece here would be looking for consistency in findings across studies, across populations, across years, across data sources, which fortunately we do see some consistency there. And so that provides us more confidence that even though there's methodological limitations that we have some general sense of what the issues are.

And I'm going to highlight four key findings from the literature on non-elderly adults: First, insurance matters, including Medicaid. Access to care is better for individuals on Medicaid than the uninsured.

Second, when we compare Medicaid beneficiaries to those with private coverage, we find that Medicaid is as good as private coverage on many dimensions, but there are some exceptions to that, and we'll talk about that a bit later.

And you've heard a bit about this earlier. Access to care under Medicaid isn't uniform. There's wide variation across population groups, across states, across urban and rural areas. So it's important not to think of it as a single program.

And then finally, some of the barriers to care

that we see under Medicaid are long-term issues. These are not recent problems, but are long problems that have been inherent for the program for years.

So my next slides are highlighting some of the findings related to these issues, and what we've done is done work using the National Health Interview Survey for 2009 to give you some of the most up-to-date information, but also to provide a consistent set of outcomes across different populations, so that it's easier to make comparisons.

So the first slide here is looking at access to care for non-elderly adults on Medicaid compared to low income, uninsured adults and looking across a variety of measures of access, whether they had a usual source of care when they needed care or needed to talk about their health, whether they had a doctor visit in the last 12 months, whether they had a dental visit, whether they reported no unmet need because of costs and then whether the family spent less than $500 for medical care in the past 12 months.

So I've tried to frame this so that higher is better for all the outcomes. As you can see here, Medicaid is significantly higher on all the measures than the

uninsured, by large amounts in most cases. So clearly, Medicaid is better than being uninsured.

CHAIR ROWLAND: Sharon, was that adjusted for health status?

MS. LONG: Yes, this is adjusted for health status. If you could read the footnote -- it's very small -- we're controlling for age, gender, physical and mental health status, disability status, pregnancy, comorbidities, body mass index and then whether the individual is a current or past smoker. So it's controlling for health care need to the best that we can with that survey.

CHAIR ROWLAND: Even though the Medicaid is a sicker population from your earlier table, in this slide you've made that adjustment.

MS. LONG: We've made that adjustment. I mean there is the limitation that we can't control for severity of illness and all conditions. But we have, to the extent the survey provides this data on health status, tried to control for health status in the comparison.

When we do the same comparison looking at non-elderly adults on Medicaid compared to low income adults with employer-sponsored coverage, you can see here we find

very similar levels of access across many of the measures. These are the same measures in the prior slide. Then the last measure we see actually a higher level for Medicaid than the ESI coverage, and this is on family expenditures on medical care in the past 12 months. So this reflects the lower levels of cost-sharing in Medicaid relative to employer-sponsored coverage.

So it actually provides more protection against affordability than what we see in ESI coverage, but Medicaid is not as good as ESI coverage on all dimensions.

So when you look across the studies on different outcomes, there is evidence of more gaps in care on some measures. Studies look at different measures, different populations, different time periods, and so it's not always a consistent set of outcomes where we see the problems, but there are some that show up repeatedly. So we often see more problems with access to specialist care under Medicaid, more problems with access to preventive care, more problems with access to prescription drugs, and dental care is another area where there's often much poorer access in Medicaid than employer-sponsored coverage.

So here, looking at the probability of a

specialist visit, a visit to a nurse practitioner, physician assistant or midwife, visit to other providers, and this includes eye doctors, chiropractors, podiatrists and therapists, whether they had a flu shot in the last year and then whether they delayed medical care in the last year because they couldn't get an appointment. So in these cases, in this year for the sample, we do see differences across those measures, with Medicaid not doing as well as employer-sponsored coverage.

As I mentioned earlier, it's important to realize that Medicaid is not a single program. There is wide variation in access within the program. This slide is looking at differences in access for parents, pregnant women, childless adults and SSI adults -- so, looking at dental care, unmet need for care because of costs and delayed medical care because didn't have transportation. So, as you can see, there's variation in terms of where different population groups are in terms of access to care.

We can look at this a lot of different ways, and you'll see that variation if we look by health condition. We see much more difficult problems with access among those with mental health issues, with cognitive limitations, with

mobility limitations. We see differences by racial and ethnic groups. We see differences across states and within states, and across urban and rural areas. So it is very much a program with wide variation in terms of where the access issues are.

And then Medicaid has a long history of problems with access to care among non-elderly adults. This slide is showing you several measures of unmet need for care. The first is the top bar, is unmet need because of costs over the past 12 months for any reason. The three bars below that are for specific types of care -- so, medical care, dental care, prescription drugs. And then the bottom purple, or I guess the gray one is any delay of care because couldn't get an appointment over the past 12 months.

So, as you can see, persistent levels there that are increasing over time under the Medicaid program from 1999 to 2009. I would say that for low income adults on employer-sponsored coverage there's also an increase over this period. So it's not just happening in the Medicaid program, but it tends to be worse in the Medicaid program.

There are many factors that contribute to the gaps in access to care under Medicaid for non-elderly adults.

Many also affect Medicaid in general, but one of the ones that's most problematic here is that many of the low income adults on Medicaid have complex health care needs, including cognitive limitations, mental health problems, mobility limitations, all of which make access to care more difficult.

It is by definition a low income population, fewer resources to deal with care issues, but it also means many live in low income communities and many have limited transportation options. So all of those make obtaining care more difficult.

You've heard a bit about this already. Lack of access to providers is clearly an issue, and this is both limited provider payments, problems with other issues with the Medicaid program, but also the spatial mismatch where Medicaid beneficiaries don't live in the communities where their providers are located. So access to care can be problematic from that perspective as well, especially when you put it back with the issue of they have limited transportation options. So that just exacerbates that mismatch.

There are some elements of the design of the

Medicaid program that contribute to the barriers -- limits on benefits, service caps, cost containment strategies -- which may make obtaining the care that's needed more problematic. There are some recent studies that have shown that some of the disabled adults on Medicaid actually have fairly high out-of-pocket costs. So they've hit service caps or benefit limits and need to pay for their care out of pocket.

In thinking about how to monitor access to care under Medicaid for the non-elderly population, it's important to track multiple populations. It's not a single population, so we want to look particularly at some of the vulnerable populations to understand how access is changing for them.

We want to track multiple measures. There's not a single measure that captures all the elements of access to care. So it would be important to have a more comprehensive set of measures.

And I think important to track on multiple data sources. This is echoing some of the things you've heard already, but we want both the quantitative data to have objective measures of access across populations and states,

but I think we also do need that qualitative data to understand what's behind some of those measures, and to get data in a more timely manner than impossible with some of the national data sources.

When I look at what's out there and what the potential data sources are for monitoring, clearly the national data sources will be important. Surveys of households and individuals, and surveys of provider visits and hospital discharge data will all have a role to play.

I think it will be important to try to encourage the spending of the money to improve the national surveys, so that they are better able to track these issues. Some of this is happening already -- expanding sample sizes in the NHS, potentially in the MEPS, adding more access questions to those surveys. There are new questions being added to NHS next year, additional ones that would be great to have as a means of tracking the Medicaid program over time. It would also be nice to add access questions to some of the other surveys with larger sample sizes. The American Community Survey is clearly an obvious target, and so is the BRFSS, the Behavioral Risk Factor Surveillance System, as ways to get more timely measures of access.

Now as an aside, I was on a panel with Bob Grove yesterday, who is the head of the Census Bureau, who laughed when I made the suggestion about adding a question to the ACS. He said the bureaucracy is awful, but I don't think we should give up.

And then on a more qualitative level, it would be very useful to do periodic interviews with key state and community informants, to try to get that more qualitative information in a more timely manner.

Another possibility is to do quicker surveys, so not relying necessarily on the national surveys but more short-term, shorter surveys of vulnerable populations or vulnerable communities, to really get that more rapid feedback in place.

And then finally, there is a very large research community out there in the states, and across academic center and research communities, that could be tapped into to provide a more coordinated set of assessments of health reform in the Medicaid population in the states. I think tapping into that might be a way to get quick feedback in a timely manner without having to spend a whole lot of money.

Thank you very much.

CHAIR ROWLAND: Thank you.

Jason, walk us through the experience in Wisconsin, please. Thank you, and thanks again for coming all the way to be with us today.

* MR. HELGERSON: No problem. Happy to be here, if I can figure out the technology.

Fabulous. Thank you. Once again, my name is Jason Helgerson, the State Medicaid Director from Wisconsin. I'm happy to be here to talk a little bit about some of our efforts in Wisconsin in recent years to expand access to health care services for our residents.

We've done quite a lot in the past three to four years in terms of creating access, but I think certainly as we look towards the implementation of national health care reform we're excited about some of the potential opportunities to really sort of fill in the remaining gaps that exist for certain elements of our population. And I'll talk a little bit about both what we've done as well as some of the challenges that remain.

So first off, Wisconsin has a long and proud tradition of helping its poorest residents have access to affordable health care. Historically, we have one of the

lowest uninsured rates in the country. Estimates range, depending on what survey you use, somewhere between 5 and about 9 percent of the population goes without health insurance at a given time.

Also, we have one of the largest health care safety nets in the country. I'll talk a little bit about some of the coverage levels, but we cover all kids; we cover childless adults; we've had a number of other non-Medicaid programs that have been created over the years -- all in efforts to sort of get at what we believe is a moral imperative, which is to ensure that all Wisconsinites and actually all Americans should have access to these vital health care services and that income should never be an impediment to that.

Generally speaking, in Medicaid and across our public programs, we're proud of the fact that we feel that our members have access to a wide array of health care services. That said, there are some areas where access remains a challenge, and I'll talk a little bit about a couple of those areas and some of the things that we've done to try to address it.

That said, I think like a lot of states, and you

could have other states come up here. Trish obviously could give her experiences, and Mike did earlier. In terms of some of those key challenge areas that remain, I think that we've had some of those common issues we face here in Wisconsin as well.

So in terms of recent efforts, a couple of things that we've done: First and foremost is our BadgerCare Plus program, a major expansion that began in February of 2008, built on our SCHIP program which started in 1999 called BadgerCare. It was actually more than just a coverage expansion. It was actually a fundamental re-look at, and a redesign of, the programs.

At the time, there were three programs that served the low income family population in our state. We merged those three programs together and radically simplified the eligibility process.

We also adopted a whole series of new ways for people to sign up for the programs because what we found was that roughly about 60 percent of the uninsured children in our state were, at least in our surveys, eligible for the programs that already existed. But yet, for one reason or another, they weren't enrolled. So one of the thoughts was

that we were creating, unintentionally, barriers to that enrollment.

So we adopted a number of strategies including going to a one-page application form. It used to be about 20 pages in length. We also significantly expanded the use of an online application tool. Now roughly 60 percent of all of our applications come via the web, which is a wholesale fundamental change from only about 5 years ago when it was about 60 percent were in-person. So it's been a total, radical shift in the way people apply.

We also have 200 community-based organizations who work with us, from pretty much every corner of the state, basically as foot soldiers in the effort to identify and find families eligible for programs and get them enrolled. The web-based tool that we have has been a godsend, really helping them move into a situation where they can be full-service application points. Where in the past they handed out forms and pamphlets, now they're actually actively enrolling people, and that has really been a godsend to us.

Also in terms of helping to ensure access, so that it's not just a card you get but that it's actually the services that you need, which I think obviously is a key

focus of this group, our primary focus has been expanded use of managed care, both for our low-income family population through BadgerCare Plus but also into our SSI population and even into our long-term care populations. Our belief has been that managed care organizations have an ability, when necessary, to pay providers more than Medicaid fee-for-service rates. We believe, and we have experience that shows, that when you hold them accountable for maintaining network standards they are capable of doing that.

And we've done a lot in terms of particularly increasing the standards and increasing our levels of accountability. Some of the things that you heard Mike mention earlier about increasing staff in areas around contract compliance in the managed care organizations, that's been another major focus of ours in the past few years.

Really for us, it's really meant a fundamental shift in our organization, managing the Medicaid program, away from a culture which was dominated by a fee-for-service mentality, where we sort of were the primary claims payer. And we found that most of our staff and most of our best staff, our most talented staff, were in an old fee-for-

service bureau, and we had many fewer individuals working in managed care. So we reorganized ourselves to shift more resources there, to really hold those HMOs accountable, and we think that's paid some significant dividends for us.

And then the other thing that I think is worth mentioning -- and I think we're going to start seeing more of these concerns, and I'd be interested to hear what this group finds as you dig into these issues deeper -- is that more and more states in these difficult economic times are finding, especially with MOE requirements and you can't adjust eligibility, that they're cutting provider rates and cutting them across the board.

We have worked very, very hard in Wisconsin to avoid across-the-board rate cuts. We were given a huge budgetary target, $600 million over 2 years. That was a 5 percent reduction in our budget. And we were able to find it in coordination with about 200 stakeholders who worked with us and developed a comprehensive plan that was really more about reform and saving money than about across-the-board rate cuts and saving money.

I think it's going to continue to be a challenge as we get towards 2014, to avoid those rate cuts because our

fear is that those kinds of adjustments lead to major access problems.

That said, access issues still do persist in Wisconsin. I mentioned a couple of areas, not surprising probably to this group, but dental care and mental health services, dental care much more so than mental health.

Generally speaking, we have mental health access we feel pretty good about. That said, we just have a diminishing number of psychiatrists, just available in the state. Our tenth largest county, we've learned that the only practicing psychiatrist in that particular county is getting ready to retire. That creates access issues not just for our population but also for the population as a whole. So I think those workforce issues that I think ACA attempts to address a little bit obviously are extremely important as we move forward.

Also, in terms of dental, I would say we've worked hard, even in an environment where we would love to be able to provide dental rate increases. But what we've tried to do is try to streamline the program, make it easier, reduce prior authorization requirements, do different things. Actually, we have a unit now that goes out and tries to

recruit dentists to join the program. We've also built into HMO contracts. In our urban areas, we have requirements that the dental benefit is built into the HMO contract. We have new requirements around dental access, but we still have a long way to go.

And then finally, in terms of access problems, not all of our benefits -- and Sharon mentioned earlier -- not all of our benefit packages, for budget neutrality and other reasons, offer the full complement of health care services. I'll talk a little bit about one of those limited benefit plans, and it has created some access issues.

So specifically, I wanted to highlight something, a recent expansion that we've done. This was back in 2009. It was an expansion to the childless adults population in our state, or adults with no dependent children. We did that through a new 1115 waiver. It was a strict budget neutrality cap, but we call it our BadgerCare Plus Core Plan, and I'll explain why we refer to it as a core plan.

First off, just in terms of just context, how this specific program fits into the broader BadgerCare Plus context: BadgerCare Plus as a whole serves over 7,000 people, and that includes parents, kids, pregnant women and

now childless adults. It really began with an expansion when CHIP first came into being in the late nineties, but then we began the expansion first to all children, then to pregnant women up to 300 percent of federal poverty. We expanded from 185 to 200 percent for parents and caretakers.

And we've done this using two benefit packages -- one which is your standard Medicaid product, and then particularly for the higher income children, we call it the Benchmark Plan which is much more comparable to commercial managed care, HMO-type products that we see in our state.

Yes?

VICE CHAIR SUNDWALL: What's the population of Wisconsin.

MR. HELGERSON: Five and a half million. Total Medicaid enrollment, just for folks' total context, is 1.1 million members, so roughly 20 percent of the state population.

In 2009, Wisconsin implemented the core plan. We started out; we had a one-county general assistance medical program, Milwaukee County, about 11,000 people. Those people were automatically enrolled into this new benefit.

And then a few months later we expanded

eligibility statewide for individuals who had been either of a couple situations. One, you had been without health insurance for a year or more, or secondly, you had lost access to insurance out of something completely out of your control, meaning you lost employment, lost your job and with that you lost access to insurance. That second factor was very important because as we were implementing this program we saw the downturn in the economy and, hence, a significant increase in the number of adults who fit into that category.

And then finally the most recent expansion is actually a self-funded effort called BadgerCare Plus Basic Plan where because our core plan was a capped waiver program and we had to institute a wait list. So we created a new, in essence, self-funded, meaning premiums were covering the costs, an even more limited benefit, and there's about 4,000 people enrolled in that program today.

In total, these programs now ensure that 98 percent of Wisconsin residents have access to affordable health care, which we feel is probably our greatest achievement in terms of health care reform.

So what is the core plan? It is a limited benefit. When we first initially launched this program, our

target audience were individuals who were the long-term uninsured people in our state. But as I said, when we actually went live with the program, the economy looked very different than when we planned this project. What it meant is we had a whole lot more interested people, a lot more applicants, and actually a slightly different pool of applicants than we had initially anticipated, and I'll give you a few stats that point to that. But it was a budget neutrality, capped program. Basically, we took our entire DSH allocation, or disproportionate share hospital payments, which is a thing, and we shifted those dollars over to provide this benefit. So we literally are paying our hospitals for no extra payments for, in essence, uncompensated care. I think we're one of the few, if not the only, states in the country that have done that.

But we do think there's some lessons because this is a population that the entire country is going to have to start covering. I think it was mentioned maybe five -- I had heard seven states cover these populations in some way, shape, or form, but beginning on 1/1/14, this is the wave of people who are going to be coming to Medicaid programs all across the country.

So what have we learned? We're still learning, but first off, the population who came and enrolled in our program -- and we had eligibility only open statewide up to 200 percent for about three and a half months. In that time, we received 72,000 applications for the program. Huge amounts of interest. Our provider community, our advocate community was ginned up and ready to go, very excited about this initiative and really worked hard to get people enrolled very quickly. It was a huge effort for us at the state. But we did find some interesting things.

First off, roughly 50 percent of the applicants were actually women, which was somewhat surprising to us. In our surveys of the uninsured childless adult population, it's always about 60/40 men, and I think the public perception is it's a bunch of unemployed men who are without insurance. I mean, I think that's kind of a -- I mean, we certainly heard that a lot when the bell was -- this effort was going to the legislature, why did we care so much about these young men. But it turned out that at least when it came time to apply, women certainly believed that -- or maybe put more value into it, maybe felt that they had a more immediate need. But we did find that it turned out to

be roughly 50/50, which was a little bit surprising to us.

The other thing was that it was a younger population than what we had anticipated. Basically, if you looked at -- if we had more time, I would have shown you a slide which showed basically the breakdown by age, and it's basically a bimodal distribution with a relatively larger number at the higher incomes in sort of the 55-to-64 range, but then almost an equally sized number within that 19-to-34 range, which was surprising to us.

But after we looked at it a little bit further, one of the hottest community access points was the Technical College in Milwaukee. It turned out that the Technical College really worked hard to raise awareness, lots of nontraditional students working part-time, don't have access to employer-sponsored insurance, parents don't have coverage to offer them, so quite a few folks came through the door quite quickly. It has helped diversify our pool of who it is, but I also think it points to lessons for how you actually enroll people. And that gets to the second point here, that 82 percent of the people who applied for this program came through the Internet. Not all those people came on their own. Some came through community-based

partners who assisted them in applications through the Internet. But the vast, vast, vast majority of people came through that way. And so, you know, I think by offering those other alternative tools, you potentially open the door and make it easier for younger workers to sign up for the programs as well.

You know, a couple final points: just that the population also had health care needs as we suspected, and we worked with our actuaries to estimate this. We looked at other states in terms of coming up with estimates for PMPM costs. But what we found is that the PMPM costs have run pretty close to what we anticipated, which we felt has been a very positive outcome.

Then also, while our members initially started fee for service, they're now all enrolled in managed care in plans throughout the state. We really have received very few complaints and concerns not only about access to the services they're entitled to, but also, frankly, because of the limited nature of the benefit, we had some concerns about people not getting the drugs that they wanted, or basically there's a very limited mental health coverage, that we thought we would get a lot more complaints about

service. But, frankly, it has not been that way. We have found, you know, that the coverage has been good, which I think bodes well for this population potentially statewide as they are going to be getting access to a benchmark level of coverage, which isn't maybe your traditional Medicaid product, but I just mention that as well.

Just some concluding thoughts, mainly based on our experience and take them for what they're worth in your important work here. But, you know, we've made health care access a major priority, not just in terms of giving people cards but making sure that the card actually gets them the services that they need. We've expanded access tremendously. We've added 300,000 people to health care in the past two years -- more than that, actually. And despite that -- and I know there's lots of concerns about increased access in Medicaid and what's that going to mean in terms of people getting services, and is it going to mean long lines waiting for primary care. At least in Wisconsin, we have not seen that. We really have not had the access problems.

To give you a flavor for that, right now there are 660,000 people enrolled in managed care in our states, both the disabled and the nondisabled populations. Of those

people, right now we currently have 12 grievances in process for managed care. So, you know, I think that if -- that to me is at least an indicator that while people are gaining access and they're in the managed care, folks at least are not complaining or raising concerns about access.

In addition, when we survey through CAHPS our managed care enrollment members, we find 80, 85 percent satisfaction with not only the services that they're getting but also with the HMOs that they're enrolled in. And so, generally speaking, we feel that despite huge growth in the program, while creating budgetary pressures, we have not had the kind of access problems that some might have feared.

Then, finally, for us the big challenge -- and I think this will be for a lot of states -- is how do we get from here to 1/1/14. This difficult budgetary time, with the ARRA funding coming to an end, it's going to be tough the next couple budget cycles for Wisconsin and for the rest of the state. We anticipate national reform providing huge savings to the state. Our estimates are that between $800 million and $1 billion worth of savings to the Wisconsin taxpayers as a result of the implementation of national health care reform, which definitely will make it a lot

easier to maintain our eligibility, which we will be required to do.

So as we see it, the big challenge for us as a Medicaid program is how do we get to 2014.

CHAIR ROWLAND: Great. Questions from the panel?

COMMISSIONER CHAMBERS: Jason, to you, but also to Sharon, since this is an adult working population, any issues with access hours, you know, extended hours or weekends? Was there any intent by the state for any of the provider organizations to try to encourage that? I'm curious.

MR. HELGERSON: Good question. Oftentimes that is cited as a reason for unnecessary emergency room utilization because you're right, you have lots of single parents on Medicaid programs who, you know, just don't have the time during the normal workday to go to take their child to a doctor or for themselves to go see a provider.

One of the things we've done that I didn't get a chance to mention is we recently did a reprocurement for managed care services in the southeast part of our state, and we significantly increased our network requirements, the most significant network reforms we've ever had in place.

But as part of that, we put in requirements around urgent care services as well as after-hours care services, which is the first time we've ever put those standards into place. So we're hopeful those contracts that -- we're just in the final stages of enrolling people into the new plans, and so we're hopeful that that will further help in those efforts.

CHAIR ROWLAND: Would you be willing to share those standards with us?

MR. HELGERSON: I would be happy to do so.

CHAIR ROWLAND: That would be great.

MS. LONG: And the issue of after-hours care is one that shows up in survey data as well. The National Health Interview Survey does include a question on delaying care because of inability to get care after hours. I don't remember the exact numbers, but it is a problem within the Medicaid program, and more severe there than among the low-income ESI. I think here's an example of the richness you can get from the state, you just can't get it from the survey data, so we don't know exactly why.

I was actually on another project where we're doing a study of the safety net, and I think other places are doing the same thing here, doing after-hours care and

Saturday-hours care to try to meet the needs among the population.

COMMISSIONER SMITH: I have two questions, but first a comment on behalf of all the parents in South Carolina with medically complex children. It's a lot warmer in South Carolina if you're ever looking to move.

[Laughter.]

COMMISSIONER SMITH: We would love your enthusiasm down there.

I have two questions, and one that you kind of answered is how do the beneficiaries who don't access -- because a lot of Medicaid families or people who would be eligible for Medicaid don't even have the money for computers or Internet service. So how do you reach them?

And, also, you mentioned that you had shifted staff so that they're holding managed care programs more accountable. How are you holding them accountable? Are there penalties? Is it just a lot of nagging on the phone?

Those are the two questions.

MR. HELGERSON: Sure. First off, in terms of how you reach these difficult-to-reach populations -- and I think that when we looked at our numbers, we saw -- well,

after years -- when we created BadgerCare in the late 1990s, we saw year-to-year declines in the number of uninsured children. Then all of a sudden, probably about five, six years ago, we started to see the number of uninsured children rise, and it was year after year. And the question was, you know, what was happening. And then you looked at the survey, and you look at, well, what are their reported incomes in the survey, and they still appear to be eligible. This is even before our expansion. You know, we did have some families, you know, with the rising cost of ESI, that you saw kids with income -- or families with incomes like at 187 percent, 200 percent, 250 percent of poverty, increasing numbers of uninsured there, so some of it is just eligibility.

But the other question is the complexity of the program, the fear, particularly with non-English-speaking or particularly for us the Latino population in some of our urban centers, fear of going to the county welfare office, the county government office to sign up for these programs.

I think we had some culture issues within some of these income maintenance offices in terms of what their role was, and we still have some of that, which is this issue

around I'm trying to keep the door closed as opposed to welcoming you in, and work still needs to be done there.

So in a lot of ways, we had to do two things. One, you had to streamline it; and, two, you had to empower community-based partners who were trusted members of the community who could reach out, find these families, and help get them enrolled. But in order to -- you can invite these groups to participate, but if you don't give them the right tool that actually allows them to be effective -- and that's really where our access website came in, which was we were able to train lots of people very quickly to use this so they could run the application from start to finish and have that person confirmed eligible. That was hugely powerful. Because in the past, you know, it was like we'd give out paper applications and people didn't know the rules, and they didn't know -- they called the same 1-800 number, they had to wait in line. And it just was never very effective. They got frustrated and decided not to work on it. I think that has been a big thing.

And then your second question was?

COMMISSIONER SMITH: How do you hold the managed care --

MR. HELGERSON: Oh, accountable. Very good point. In the past, it was -- there used to be a phrase, and some of the folks who had been around the program for a long time used to say, "Well, it's not good managed care, but at least it's managed care." And I think what we've tried to do in the recent years was to say that's completely unacceptable, and that we pay these companies a lot of money. You know, we spend in capped payments on the BadgerCare Plus side $1 billion a year. We have one of the highest administrative rates in the country, and what we decided was enough was enough. You sign a contract, we are going to hold you accountable. If it's a network requirement, if we detect that there's a network issue or we get a complaint, we investigate. That includes cold calling providers and their networks, basically a secret shopper-type effort to determine are you not only in the network but are you accepting new patients. You know, there's a number of things.

But I think in southeast Wisconsin -- we're happy to share this as well -- what we've also done in this RFP if we put more money at risk, 3.25 percent of the total capitation payment is now at risk, which we think is the

most any state has ever done, and maybe what needs to be done if we don't get results is to put even more at risk based on actual performance. That is health outcomes, that is access to care, it's a number of different things. But in a lot of ways, our belief is that when you put money at risk, you'll see improvement. We've done that in the past with Health Check, and we saw a significant increase in the percent of our kids getting Health Check, and that was because money was at risk.

And so our hope is that through a combination of enhanced surveillance and real money at risk, we're going to continue to see improvement.

COMMISSIONER HENNING: First, let me compliment you on the name of your program. I think "BadgerCare" has got to be one of the best ones I've heard.

I guess my question is: Have you seen the working poor drop their employer-based coverage in favor of the BadgerCare program? Because I know that premiums keep going up for employer-based insurance programs, so it seems to me that if you qualified by income, you might be better off going to BadgerCare.

MR. HELGERSON: Very good question. In fact, we

have an outside evaluator that's going to be completing their work in the next month or so, and one of the key issues of the BadgerCare Plus expansion, one of the key issues is the issue that is always debated about increases in eligibility for Medicaid, which is: Does it lead to crowdout? And as part of that evaluation, they are taking a long, hard look at that issue.

You know, so far it's hard -- without real good analytical work and data analysis, you know, looking at it from my vantage point is hard because we're also looking at a huge downturn in the economy. You know, part of our growth was because we expanded eligibility, simplified enrollment, procedures; part of it is just because the economy tanked, unemployment doubled, and so it's hard to tell. But that is one of the key things.

Past studies of our programs have indicated that we've had less crowdout. We do do a lot around verification of those higher-income folks. Do they have access to employer-sponsored insurance? We now have a database of 40,000 employers in our state in terms of what health insurance they offer to what employees, and we check against that database when people apply. And if you got

eligibility, you know, we can check against that. Is it a foolproof method for checking eligibility or checking access to employer-sponsored insurance that's affordable? Not perfect, but I think that the study will come out in the next month or so, and I'm happy to share it.

COMMISSIONER COHEN: Thanks to both of you for your great presentations. A question primarily to Sharon, but I'd be really interested in your perspective, too, Jason.

It seems like, you know, based on your presentation, this category that we've always sort of had to use of non-elderly adults is sort of -- it's meaningless. You know, it's not really a good category. And as we're moving towards a period in a few years where sort of categorical eligibility goes away for many populations, I'm interested in your thoughts about what are the right categories for us to be analyzing for purposes of access.

MS. LONG: Well, I think in some sense the categories we have now are populations that were targeted because of particular needs, so pregnant women, disabled adults, parents of low-income children, and then childless adults got left out as not of much interest.

I think as we move forward under the Affordable Care Act where we're covering nearly all adults up to 138 percent of poverty, that becomes much more of a uniform population. But you'll still want to know how are the disabled doing, how are pregnant women doing.

So I think it still will be important to track within the different populations because they do have different health care needs and different vulnerabilities and different costs, which will have implications for the program.

COMMISSIONER COHEN: Just like you were talking about this bimodal distribution in terms of age, is that meaningful or not meaningful?

MS. LONG: Well, it certainly is meaningful in terms of health care needs, so I think when you think about women, you have reproductive issues at younger ages; you have chronic conditions at older ages. So I think there is some value to looking separately by age, you know, within the population where you start dealing with home and community-based care, institutional care, that those are other pieces of the story that are part of the cost of Medicaid, and a big part of the cost of Medicaid, that are

on the table as well. So I think it isn't that you can look at adults all as one group, but important to think about the range of issues there.

CHAIR ROWLAND: Certainly when we move over to looking at the payment side, we want to make different risk adjustments for the capitation rates or whatever. So there it becomes even more important to look by category.

COMMISSIONER COHEN: So do parents -- like parents versus other adults, for example, is that a meaningful distinction?

MS. LONG: I think part of the focus on parents is to get children in, and so there's been more kind of covering the family, and so that's -- low-income families was the goal initially under the TANF program with the Medicaid tied to that, or AFDC with Medicaid tied to that. So that was the issue.

In terms of health care needs, probably not, but they do have different experiences with the health care system, different interactions with the health care system.

COMMISSIONER RILEY: I always like the balancing act because the access issue is so troublesome and complicated. Could you speak a little bit more on access?

Because you just talked, Sharon, about they're not one big population, but Medicaid tends to provide one standardized benefit. Could you speak a little bit to the core benefit package and what it looks like? I understand that you use the DSH money to pay the hospital costs so that the premium only has to cover everything else?

MR. HELGERSON: No. Actually, we took our DSH allocation, in essence, and we have basically taken those dollars under the budget neutrality agreement and just use it now, I guess, in essence, to pay managed care companies to provide a limited set of Medicaid services to a distinct population. So in a sense, it's not really -- the payments are not directly to the hospitals but through the managed care companies. So it really has nothing to do with direct hospital care.

COMMISSIONER RILEY: I'm trying to get at what is the core benefit, and what does the premium look like that covers it?

MR. HELGERSON: Premium, there is no premium. It's a $60 application fee, one time, a once-a-year application fee. The rest of the cost sharing is for between 0 and 100 percent of federal poverty. It's what we

call nominal co-pays, your traditional Medicaid co-pays. A little bit higher in a few areas between 100 and 200 percent of federal poverty.

The benefits are limited in the following ways: one, they don't have access to the complete drug formulary of the traditional Medicaid population. We went through class by class and tried to come up with a formulary that was complete enough. We do make a few exceptions here or there, but we've only made about two or three exceptions where individuals absolutely couldn't use the preferred agent, so we tried to create an out for us.

What we've also done is probably the other biggest limits are on therapies and some of those services where it just overall caps. I think it's about, you know, 20 -- a cap total on therapy service is about 20. The other main thing is we do not cover most mental health services or behavioral health, instead rely on the traditional county-based mental health and behavioral health delivery system where these people were in essence eligible for it in the past. That's probably the biggest actual limit. And what we are now proposing in CMS is to cover a small subset of additional mental health and behavioral health services.

That's currently pending with CMS because we had to come up with a way to sort of do it.

The other uniqueness of the core plan is that we actually under our waiver have a special committee of providers, of clinicians, called the Clinical Advisory Committee on Health and Emerging Technology, CACHET --

[Laughter.]

MR. HELGERSON: I didn't come up with it, but, yes, it's pretty good -- whose job it is to advise the department on modifications to the benefit. So we do a deep dive and we've got lots of data now on the services they use, the diagnoses codes, the health care we do -- we require a health needs assessment when you apply. So based on that, how do we structure the benefit that lives within a cost limit, serves as many people as we can providing the services that they need. And it's a tradeoff.

So as a result, not everyone in the program is going to get everything that they need, but we try to, to the degree we can within the budget, make it work.

COMMISSIONER RILEY: And that would explain -- that answers my question, because in our travels, adult mental health is a huge cost driver.

COMMISSIONER CARTE: Jason, you had mentioned that over 80 percent of your applications were online and credited your community partners. Could you say a little bit more about what type of partners? And do you provide them contractual support? Also, if there were any other significant streamlining activities other than the shortening of applications that I think most states have gone to by now.

MR. HELGERSON: Sure. First off, in terms of the community-based partners, it ranges from sort of your traditional health care providers: federally qualified health centers, rural health clinics, other types of just general providers, hospital systems, a number of those types. Then, you know, it gets into the Boys and Girls Clubs, the public health departments that are county-based spread all across the state. That has been a rich area for us. Child care providers have also been -- some of the child care coordinating entities that are based in communities. The idea is trying to identify anyone and everyone.

We started the process by giving out some grants, basically small -- we called them mini-grants, to buy

computers, get Internet connectivity, that kind of thing. We offered them whatever training they wanted and had built this network and maintained it. The other thing we offered them was customer service, which was they have their own contact person or people, they have their own phone number. When they have an issue, we try to provide them with very quick, good customer service. They're not going through the traditional route in terms of that.

And then in terms of -- I'm sorry. You're second question.

COMMISSIONER CARTE: About do you provide them contractual support and whether any other significant streamlining -

MR. HELGERSON: Yes.

COMMISSIONER CARTE: Electronic signature, stuff like that.

MR. HELGERSON: So we don't require them to sign contracts with us, and there are varying levels within those 200 in terms of how much they do, how much volume they have. Some are very high, some are less. But we don't actually -- outside of the mini-grants that we gave out a couple of years ago, we don't really sign contracts with them. And we

don't actually directly pay them. The contracts they got and the grants they got were performance-based, so they actually had to help sign people up in order to get the full grant. But those grant dollars have now been spent.

In terms of streamlining, yes, significant, more than just the one-page application form. We used to have lots of disregards and all kinds of modifications, income. We scrapped all that. We went to basically -- it's a gross definition of income. Hugely helpful in streamlining the application process because it makes it a lot easier for someone -- whether it's a county worker or a state worker or a community-based partner -- to help get -- you know, what's the income off the check stub and enter that into the system, which has really made it a lot simpler. So we greatly eliminated that.

We reduced reporting requirements. You don't have to report as much. Basically unless you have a significant change in income that moves you completely out of eligibility, you don't have to report any of those changes. So, you know, a number of different things along those lines to try to make it easier to apply and stay in the program.

CHAIR ROWLAND: Okay. Thank you both very much.

I think this has been very instructive and will help guide us in many ways as we move forward.

Now, in lieu of a break, since Penny Thompson's schedule is a little tight, I'm going to ask Penny to come up and begin our next panel, and then we'll take a break after Penny leaves.

So I'm pleased to welcome Penny Thompson, the Deputy Director of the Center for Medicaid, CHIP, and Survey and Certification at CMS. Penny was with us in September and the discussion was so engaging that we asked her back to continue to talk to us about the CMS initiatives to improve data for program operations and evaluation. So Penny, kick it off. Thank you.

CMS INITIATIVES TO IMPROVE DATA

FOR PROGRAM OPERATIONS AND EVALUATION

* MS. THOMPSON: Thanks for inviting me back, and I apologize for the fact that I have to run off at 3:30 and I'm keeping you from an official break, but I see people are doing what they need to do.

So we know that we wanted to have a more fulsome discussion about where we're going with data, and I know that you're going to have a staff presentation, after I stop

talking, about some of the key data sources and what they're all about. So I won't spend a whole lot of time going through a lot of information that you'll hear later. But I do want to set the stage for why we're doing what we're doing and where we think that MACPAC can help us in going forward.

We always try to remind ourselves, I mean, usually we don't need this reminding, but it's useful to make this point every time we have a conversation about data, which is that our job is not to create wonderful data repositories. As much as sometimes that can become kind of the consuming ambition of the people that are involved in working with data, the purpose of the data is to actually contribute to accomplishing our missions.

And so, we're really always asking ourselves about the value of the data and the value of the exercise in terms of how will this help us do our jobs as an enterprise. And our aperture for that is not just within CMS. It's also thinking about how will this help states do their jobs. How will this help the larger community of interested people contribute and collaborate with us in doing our jobs?

And so, this last point about partnerships is

really critical to reinforce when we talk about data because we see the construction of data and the availability of data as critical to helping us achieve our overall program missions.

Again, sort of thinking about the business purpose of the data environment of the accumulation and acquisition and availability of data, why do we care about data? What is it that we want data to do for us and help us do? And these purposes are intertwined. We want to manage program operations. We want to make sure that we're defending the program in terms of its integrity. We want to keep advancing the program in terms of effectiveness and efficiency. We want accountability for ourselves and for our state partners. We want transparency to the public and collaboration with partners. We want researchers and other analysts to help us understand the implications of the data and of our program decisions.

In many cases, many of these functions are sometimes carried out by individual business units, and typically what we've done in the past is people who have had specific business needs have gone out and tried to figure out how to address those business needs through their own

accumulation of data.

We're really trying to think about this in a very different kind of way in terms of the larger enterprise. Someone who cares about accumulating data and looking at data for the purposes of program integrity, in many ways, is looking at the same kinds of data, and sometimes in some of the same kinds of ways as a researcher who's interested in understanding what are we paying for and what's the value of what we pay for.

When we talk about program administration and we talk about what is it that we would like to know about the programs and how they're operating, those are some of the same questions that states have. And so, what we really want to do is chart a path forward in which we really look at all of these business needs and try to address them as a complete enterprise.

Now, of course, the Affordable Care Act has some specific provisions related to data and reporting that we have to be mindful of. Section 6504, which talks about the fact that data elements from Medicaid Management Information Systems that are necessary for program integrity, program administration, and program oversight need to be supplied to

the Secretary.

Section 6402 mentions the Integrated Data Repository. This is an initiative that CMS has had underway for some time, and talks about acquiring and placing both Medicare and Medicaid, as well as some other program data, including CHIP, into the Integrated Data Repository. It establishes the desire for Medicare and Medicaid data to be placed in that Integrated Data Repository as the first priority, with the other programs as second priorities.

And also in Section 6402, there's a provision regarding submission of encounter data and the fact that CMS may apply penalties in the form of FFP withholding for states that fail to submit their encounter data to the Medicaid Statistical Information System.

There are also other provisions. Section 4302, which talks about health care disparities and a desire for more information about race, ethnicity, sex, primary language, and disability for applicants, recipients, and participants in programs. And then in Section 2001, there's a specific provision relating to reporting enrollment and eligibility information.

But while all of those individual provisions are

very important and need our attention and we have to be sure to implement those provisions, more broader than that is the fact that the Affordable Care Act, as you know, contains a wide range of provisions that fundamentally transform the Medicaid program. And we talked a little bit about this last time we were together.

And it's really that entire new structure that we're looking at that changes the way that we think about data. It increases the demands on us for data, the demand on us for reporting and transparency around -- as new people come into the program, have they entered the program in a way that's accurate and efficient. What kind of services are they accessing? What is their care experience? How are we improving their health?

Dr. Berwick, the administrator of CMS, talks about the triple aim, the triple aim that has to do with improving the care that people receive, improving the health that people have, and reducing per capita costs. And so, when we talk about what do we really want to know now and what are we really going to want to know in 2014 and beyond, it's really about those three things. How are people coming into coverage? What is the care that they're receiving? What is

the impact on their health? And what does it mean in terms of our overall health care costs?

So we have a variety of data sources. These are a few. I know that you're going to talk particularly about several of these in a little bit. Probably the most substantial, at this point, from a Medicaid standpoint is this first one, the Medicaid Statistical Information System. That's the reporting that states do on claims, expenditures, encounters, and individuals, and to CMS on a quarterly basis.

It was mandated by the Balanced Budget Act of 1997. Before BBA, we had hard copy paper reports that came into us on an annual basis. After BBA, we moved to an electronic reporting system and it's submitted on a quarterly basis.

So that data comes in from each state on a quarterly basis, although some states, depending on some issues, may be late in submitting some of their quarterly data. Some states, if they're doing a replacement or significant change within their Medicaid Management Information Systems, may have trouble producing some of the data. Some states may have some gaps in technical expertise

in terms of producing the data to us. So we don't always get all of the data reported to us on a quarterly basis. I'll talk about that in a second.

In CHIPRA there was a provision that required some reporting of CHIP enrollment and eligibility data into MSIS and we instructed states about that in August through state Medicaid and state health official letter. So there is some CHIP data inside of MSIS and there is some CHIP data when we have a Medicaid expansion program. We haven't typically had CHIP data within MSIS for separate CHIP programs.

Right now in terms of where we stand with that data, and also I'll talk about MAX as well, for FY 2008, all states are complete in their MSIS reporting with one exception. For FY 2009, 35 states have all their eligibility files approved and 37 have all their claims files approved. And for FY 2010, 33 states have some files approved.

I'm going to talk a little bit about some of the data challenges that we have, but I'll just pause on that timing for a second to reinforce the point, that we are, still at this point, trying to finish calendar year 2008 and we are still, maybe a little bit more than halfway done with

fiscal year 2009, and really not close to being done with fiscal year 2010.

So if you're looking for current data, and you're looking for something that can tell you what's happened in a program within the last month or within the last six months, depending on the state -- and some states are very timely and very good about their reporting of MSIS data, but on a national basis, MSIS cannot be the answer to that question on a consistent basis.

Now, MAX, which is the Medicaid Analytic Extract File, is essentially, although some folks will dislike my characterizing it this way, another version of MSIS. It has a bit more data than MSIS. It presents the data in a slightly different way. It has some additional verification of some additional data elements. But today, if you looked at MAX and you said how much of MAX is MSIS, about 95 percent of MAX is actually MSIS.

So a lot of the shortcomings that we would talk about with MSIS also applied to MAX, especially in terms of timeliness, because it is so reliant on MSIS as its essential foundation.

So for MAX, we have work in progress to get

through the end of 2008 -- let me double check -- yeah, to get to the end of calendar year 2008, which we hope to do this winter. So again, two-year-old data plus in terms of a national view.

We have a variety of other data sources that I won't spend a lot of time on other than just to say that for other purposes, financial data is largely in our Medicaid budget and expenditure system. So if you want to know information about states' spending in total or what states are claiming for the purposes of drawing down federal match, that's in MBES. CARTS and SEDS are really CHIP-oriented reporting systems. And we have other data warehouses and databases as well.

So what's the strength of some of the data that we have? Well, we have a lot of data. There's a lot of it. And it's national. So to the extent that we're trying to look at something across the country, the data that we have is useful for doing that. And this is a strength that can also lead to some of the weaknesses.

We don't spend a lot of money acquiring and obtaining and maintaining this data. Our level of investment is very parsimonious. And one of the things that

I think that we have to really think about is, is to what extent we need to change some of those economies in order to really accomplish some of the advances we need to accomplish.

So what are the weaknesses in the data? A slightly longer list. One is that we have data gaps. So we have some pieces of data that are missing. One of the big ones that I know that you all are very interested in is encounter data. So while states are required to submit encounter data under MSIS, not all do. And we have not applied a great deal of quality reviews on the encounter data. So the encounter data that we do have is incomplete and it hasn't been cleaned and verified or validated by us through the kinds of normal mechanisms that we've used with claims data.

I mentioned CHIP data. In MSIS we have some CHIP data, but we don't have CHIP data from all programs. Data quality and timeliness is an issue. Sometimes the reason that we have issues with the timeliness of some of the data is because we have quality issues. So data comes in, it goes through a set of screens or a set of quality controls, there are issues.

There has to be some back and forth with the submitters around what accounts for some of those potential problems, or is there an explanation. Then maybe there has to be a rerun of the data and so forth and so on. So the data quality issues directly relate to timeliness.

But even beyond data quality, the fact is, the data comes in on a quarterly basis at best. And so, I think in some cases, we have to ask ourselves if that even would be sufficient for us in terms of all of the business purposes that we talked about earlier.

The availability of data. The data is not stored in ways that make it easy to manipulate, to reach, or to produce. And so, consequently, though many, many people take advantage of the data that we do have and many people do excellent work with much of the data that we have, especially MSIS and MAX, it is not widely available to people who don't make a living working with MSIS and MAX data.

So if you were somebody who simply was interested in health care and you weren't necessarily somebody who is an expert on Medicaid or an expert on Medicaid data files, you would find it difficult to work with our data. And so,

that consequently has an impact on the kinds of people that are looking at our data, making use of it, and thinking about it, which is something that is of great concern to us.

We have a multiplicity of systems, and therefore we have a multiplicity of versions of the truth. And this is just federally. If we expanded it and thought about the enterprises, we're trying to think about the enterprise in terms of the federal-state and we would say, okay, what happened in the last month or what happened in X quarter? Well, are we getting that information out of MAX or are we getting that information out of MSIS? Are we getting that information out of MBES? Are we getting that information out of a state? Depending on where we went to get that information, we would always have a slightly different and maybe even more than slightly different answer to that question.

And that consequently introduces all sorts of issues around what are people really looking at and are we even talking about the same facts when we try to understand our program.

The underlying infrastructure. I mentioned the fact that just some of the technology that we have, the

platforms that we have some of this data sitting on don't allow it to be easily manipulated and made available.

And then there are the demands on the states. So for all of the problems that we're talking about in terms of our current information infrastructure, we have a lot of people asking for data from states, because what they're looking for isn't exactly available. And so people are asking for states in many different settings and many different ways, creating a lot of resource issues for states without even really the business value at the end of feeling good about what we have.

So I think that that's an issue that we have very much front and center about not only how can we improve the information platform for the enterprise, but how can we do it in a way that actually reduces the costs and burdens on states.

We mentioned last time that we created this Solutions Council within CMS to take on these sets of issues and really think about where do we need to go. It's the Medicaid and CHIP Business and Information Solutions Council. It's really about -- within CMS -- beginning to think about the enterprise.

We have different business units within CMS who care about Medicaid. Obviously we have our center, the Center for Medicaid, CHIP, and Survey and Certification that has direct programmatic responsibility with regard to Medicaid and CHIP. But we also have our Office of Financial Management. They care about what our audit reports look like and our financial statements look like, and some of the data issues that we have create problems in reconciliation for financial statements.

They also have responsibility around our Payment Error Reduction Measurement Program. We have folks in the Center for Program Integrity who want to look at Medicaid data for the purposes of identifying where there may be vulnerabilities across the country in terms of particular policy issues or particular provider types and so on.

We have a program called Medi-Medi in which we match Medicare and Medicaid data for the purposes of looking at program integrity. We have folks who are going to be now in the Center for Medicare and Medicaid Innovation who are going to be very interested in thinking about where do we go in terms of service delivery changes and where do we go in terms of payment reform and they're going to be eager and

wanting information from us.

We have an Office of Duals that will be interested in data and looking at data in a combined way between Medicare and Medicaid. We have an Office of Research and Demonstrations that is interested in, again, thinking about new ways of doing business and they will be interested and are interested in Medicaid data and in supporting researchers who are interested in Medicaid and CHIP data.

So all of those business units --

CHAIR ROWLAND: And you have MACPAC.

MS. THOMPSON: And we have MACPAC, absolutely, who we're delighted to be working with on these issues who will be simply another group of people who will want and make demands of data and will ask us, can you run it this way, can you change it this way, can you produce this?

And we have, obviously, our state partners who are very interested in thinking about what investments we can make on behalf of the enterprise to help them understand how their programs are doing.

So we commissioned a set of initial activities. The first thing, which is always the good first thing to do, it's some of what you guys are doing here, which is to

simply say, what is happening now? Because it wasn't always clear to everybody within the CMS enterprise as to who was using Medicaid and CHIP data or who was asking states for Medicaid and CHIP data.

So one step that we simply took was to bring everybody together in a room and say, What is it that you're trying to do in terms of your business with Medicaid and CHIP data and what data sources are you using and what is it that you're asking states for?

We convened a set of internal work groups at the staff level. We commissioned a report from Mathematica, and I have to say Mathematica did a great job for us. We gave them a ridiculous time line of 90 days and asked them to go around and do some interviews and produce some ideas for us to help us with this process. I'll talk about some of their findings in just a second.

And now we're beginning to put together a framework of a To-Be Plan, what would we like to see just from the CMS perspective, what would it look like for us? And we have some ideas about how you can help us with that in terms of going to the next steps with exposing that to a wider audience and getting some input from folks outside of

our agency.

So I mentioned the Mathematica report and I know that you guys were particularly interested in hearing about that, too. Again, it was really focused on CMS needs and the CMS business owners within our agency. They held a number of in-person meetings accumulating information from people about how they used information today, where did they go for information, what information did they wish they had and how would that actually affect the way they did their business, and presented that information along with some very detailed information on data elements and what potential data elements people were interested in.

I'll say that a couple of things that they noted which affirmed, reaffirmed, I think, some of the viewpoints that a lot of people within CMS held about where we are today with Medicaid and CHIP data is that there are a series of challenges here having to do with the complexity of the program and the fact that we're essentially dependent upon and using state data, which varies in its own form and format.

And so, how do you convert? One is knowing programs operate differently and they're not all designed in

the same way. And then two, how do you convert the data that they have into a standardized national format. What's the easiest, quickest, best way of doing that, while appreciating why some of the data varies in some of the ways that it does so that you don't lose some of those important distinctions.

And then, I think Mathematica also reaffirmed the fact that we have a technology environment that we need to work on, so we need to actually do some more investment in terms of our underlying infrastructure so that as data comes in, it can be more easily analyzed and made available to other folks.

So this is a kind of graphic representation of a potential To-Be model, and we say potential because we're sort of working with this and kind of scratching this through on a day-by-day basis. But there are a couple of points that I think are useful to think about in terms of where we want to go.

One is to think about the fact that we need both operations and program data. And so, operations data, let's characterize that as expenditure data, claims data, encounter data, beneficiary data that tells us about people

in the program, that tells us about providers in the program, that tells us about the services that are being delivered through the program.

And then program data. That is the data that now we would call state plan and waiver data, the data that describes choices that states have made about how they organize their programs. Today, much of that information exists in paper form. And so, for all of the information challenges that we just talked about in terms of things like MSIS and MAX data, at least it's in electronic format. State plan and waiver data, for the most part, is in paper format.

We've done some work recently -- we mentioned this last time we were here -- in support of the healthcare.gov website to structure program data, but it required a manual effort to pull that information out of state plans and waivers. It required a significant amount of resources on our part, and on the part of states, to validate that what we pulled out is actually correct.

And we will need an ongoing way of updating that information. So we have to think about structuring a new process for submission of electronic information in support

of state plans and waivers, and then the harvesting of structure data from that submission so that it can be made quickly and easily available.

We'll always have to maintain legacy data, so we know that in some form and format we'll have the traditional MSIS and MAX and other data that is relevant, but we also really need to think about data integration and master data management in a way that really allows us to move forward with easier and better feeds from states. That's going to require data standardization and data models to create the standardization necessary in order for that information to come in and be quickly mined and analyzed and available.

This is a representation of what we're asking states to do today in terms of sending us information. I didn't look at each one of these bubbles, so I think that's probably correct. There's probably even more that we could think of to add to this.

But when we think about this, we think about what's -- we don't want it to be completely a CMS centric process, so we have our needs. We have our ideas about what we would like, but we shouldn't just be going out that's in a very limited way thinking about only ourselves. We should

be thinking about this, as I said, as an enterprise.

So the enterprise is us, it's you, it's the states, stakeholders, it's providers, it's researchers, it's all sorts of people who are interested in our program who can help us think about whether we're doing the right thing who can give us some insight into the difference in terms of a state that may go about business one way and a state that may go about business a different way and which one is getting the greater value or which one is getting the greater quality in those services and what do we draw, what kind of lessons do we draw from that? We want that larger enterprise to be represented and those business needs to be represented in our road map.

But obviously, we're very, very cognizant and concerned about states. We know that they are under a lot of pressure today. They have a lot of demands coming from not only us, but from their own stakeholders. And so, this situation in which we're making lots of different demands for, sometimes and often the same data just in slightly different ways, maybe with slightly different time frames, is something that we really have to change.

And what we really want to see -- it's easier to

draw it than to make it happen -- is something that's really a much more holistic and uniform and unified way of supplying all of the data to an integrated data system within CMS that then becomes available and accessible very quickly to each of those states that contributed.

So that's another piece of this that we want to be sure to emphasize, which is the idea that sometimes, I think, states feel that they give us a bunch of information and they never know what we do with it and they certainly don't make any use of it.

That's another obstacle to quality and to timeliness, which is that if you can't see the value of what you're producing and what you're providing to somebody else and it isn't important to you, it's unlikely to be something that you're going to put your best resources on and you're going to put at the top of your priority list.

So it's really important that as we think about this enterprise, we think about how to make this serve the needs of states and how we make this useful to states so that they can be partners with us and be as excited and be as interested and be as committed to getting this data into us and available as we want to be ourselves.

And then we've got to do our part by keeping the discipline. And once we get here, not going back here, because it's very easy to create a new process and a new enterprise solution and then go off and say, yeah, but, that doesn't tell me this and I need that so I need this special new feed. It's a constant discipline to stay within this kind of structure.

And so, I think that really by committing ourselves publicly to the idea that this is what we're here to accomplish and sticking with it will avoid kind of that constant rework.

So let me just stop and then talk about our next steps and also about where we are eager to work with MACPAC, of course, wherever MACPAC would like to work. But our suggestions.

We really feel like we've gone through a good process internally. We still have some more work to do to really just nail down and refine what we think we can do. There's an issue of practicality here. There's an issue of resources, an issue of feasibility. So we can have great ambitions. We can have a great business case, but we've also got to be practical about what we can accomplish in

what period of time.

So we're going to have to go through some amount of sorting. We will not get to nirvana in a year or two. It will be a progression and what we need to do is make sure that the priorities that we're establishing about how we progress are the right ones.

But I think that very soon we are in a place and at a point where we really need to engage the larger community of stakeholders and that's states. It's also researchers. It's also people who have been working with the data and have direct experience in understanding what it does do and what it doesn't do so that we are sure that as we go down this pathway, we don't break what's working as we're trying to improve on the totality of what everybody has available to them.

I think that it would be extremely useful for MACPAC to think about acting in that kind of a convening role and that role of exposing some of our thinking in a collaborative atmosphere with those other groups of people.

It's also very useful for us to think about your help in terms of where are states today. States obviously are also engaged in their own activities around improving

data. And so, what do those lessons tell us? How can we take advantage of that? How can we avoid re-inventing the wheel if somebody has already solved some problems? How do we make sure that we go out and we know what those solutions are and just start to embed them in the total enterprise approach.

How hard or how difficult is it going to be for states to migrate to a different way of doing business with us? For all the motivating factors we'll make life easier, you'll get something out of it, you'll get better information yourself. There are always some practical issues about do I have the time, what are you really asking me to do, how different is it from what I'm used to doing, do I have the technical expertise.

Are there some technologies that we can push out to the states so that states don't have to invent some of the solutions themselves or some things that we can do to standardize the process of both collecting the data, cleaning the data, and submitting the data so that some of the data quality and timeliness issues are addressed at the data source rather than addressed at the federal level when the data is submitted.

So those are some things that I think we could fruitfully talk more about in terms of how we might work together going forward. So let me just put an end to it there and ask for questions.

CHAIR ROWLAND: Thank you. Questions for Penny? Mark?

COMMISSIONER HOYT: Sure, I'll ask one.

So we talk about pay-for-performance frequently in the clinical sense. I'm just wondering about applications here. It seems like, I'll just confine the remarks to managed care contracting maybe 70 percent of Medicaid people. Enrollees are now in managed care contracts. So we've expressed this frustration for a long time around encounter data. Have you given thought to just establishing a set of standard sanctions or else rewards to managed care plans that henceforth and forever more would become part of every managed care contract a state signs? Because we want this and personally I just don't think we'll ever get it unless we attach money to it.

MS. THOMPSON: Well, certainly, as I mentioned, the Affordable Care Act contains a couple of provisions directly at that point that we'll have to be issuing

regulations on and we're in the process of developing policy around those points. But I think that those Affordable Care Act provisions reflect some of the frustrations that you're expressing, which is we need the plans to submit the data and we need the states to submit the data and we need it to happen in a way that is timely enough and high quality.

And so, the provision I mentioned, for example, about FFP with regard to states, obviously that's a state-related potential sanction that we have to describe and define and quantify, but there's also provisions relating to what states can require of managed care plans within their contract provisions, and we do think it's important to carry that forward so that there's accountability at each stage in that process.

VICE CHAIR SUNDWALL: Penny, is what you're describing in this new way of doing data, which is most welcome. It's very exciting to think about. But is it a technology problem or is it really just how you structure what you need? What I've been thinking about as you've been speaking is wondering if the work of David Blumenthal and the ONC people in promoting a brave new world of exchanging information electronically has been very, very stimulating

to states, and I think is moving us in the right direction.

But is what you're talking about really how do we think about what data you need, or is it will you benefit from the new technology, because all of us are doing a lot more electronic data exchanging databases, whether it be newborn screening or CDC reportable diseases or the immunization registries, things we used to sit on in silos which are now becoming made available across the state.

MS. THOMPSON: I think that's an excellent question and I would say there are business issues, program issues, and there are technology issues. Most folks would say that the challenge is more on the business side than the technology side. There are, in fact, technology solutions and we would never want to underestimate the difficulty of some of the technology deployment or technology projects that we need to put in place to make all of this work. We all know those require investments and they require technical expertise, and those are certainly challenging.

But they're technical problems and they're solvable technical problems. And certainly, as you point out, they're technical problems that are not different from other technical problems that other people are solving in

other parts of the country in other ways.

And so, I think really the construction here is of making the programmatic and business mission aligned with the way that we use information and making the connection for everyone's benefit about the fact that we want to be an information and data culture in which the decisions that we're making are fact-based decisions, and that we're working together in a collaborative way, looking at the same sets of facts.

We may draw different interpretations or do different analysis, but that fundamentally, we're all appreciating the fact that data means something, data makes a difference, and data is the first place that we begin when we try to understand how well we're doing or what problems we're facing or whether our solutions have produced the intended outcomes.

CHAIR ROWLAND: Penny, I'm mindful of your time, so I want to thank you very much for joining us today. I know we will want to continue to work with you and that this will be an issue at the center of many of the deliberations at this Commission. So you can expect to be invited back and we welcome the opportunity to review and convene with

you.

With that, we're going to take a quick ten-minute break and then resume, since we've been sitting here for quite a while now. Thank you.

[Recess.]

CHAIR ROWLAND: If we could reassemble, please.

Well, we've been on a little bit of a "walk through data land," and we'd like to continue walking in the Medicaid data steps. So we've asked April Grady, our principal policy analyst on MACPAC, to go through some of the key Medicaid and CHIP administrative data sources so that we could get a little more familiar with all of those floating objects that Penny had up on her slides. So, April, lead us through our next discussion, please. Thank you.

STAFF BRIEFING: REVIEW OF MEDICAID AND CHIP ADMINISTRATIVE DATA SOURCES AND IMPLICATIONS FOR POLICY ANALYSIS

* MS. GRADY: Thank you, Diane. Good afternoon, everyone. I'm pleased to be here with you to continue the conversation that Penny started on administrative data sources that are commonly used in the Medicaid and CHIP program. Diane talked about our walk through the data.

I'll probably jog a little because Penny has covered some of this, and I don't want to waste everyone's time. But I do think it's important.

One of the reasons we're having this conversation today is that MACPAC has a statutory requirement to review national and state-specific Medicaid and CHIP data and to submit reports and recommendations based on those reviews.

I'll build on Penny's presentation by providing more detail on three federal administrative data sources that serve as the basis for most national and cross-state analyses of program enrollment, expenditures, and service use that we do. And, importantly, I want to tie this back to analysis of policy issues. So why do we use these data sources and what can we get from them? And given that MACPAC is likely to use these three sources frequently in its analyses, we wanted to be sure that you all had a strong understanding of their content.

In addition to describing the content, I'll also highlight some areas, sort of reinforcing what Penny said, where data improvements could allow for policy issues, and finally, I'll describe some next steps that we could take regarding the administrative data and some other sources,

and I look forward to your comments and suggestions on these issues.

The first data source I'll talk about is the Form CMS-64 and the Form CMS-21, and these data sources come from the Medicaid and CHIP budget and expenditure system that Penny mentioned. As the name implies, these are forms that state Medicaid and CHIP programs submit on a quarterly basis in order to receive federal reimbursement for a share of their program costs. Each state's total expenditures are reported for various types of service provided to enrollees and for administrative activities. And we don't yet have complete 2010 data because the fiscal year just ended, but fiscal year 2009 data from the CMS-64 shows that total federal and state Medicaid spending was about $379 billion. It's getting up there. About 95 percent of that amount was for benefits, and about 5 percent was for state administrative activities.

A second key data source which Penny did touch on is the MSIS, and that stands for Medicaid Statistical Information System. States are required to provide five detailed MSIS files on a quarterly basis. One of those files has information on reach person enrolled in the state

Medicaid program, and four of the files have information on claims for provider reimbursement that were paid by the state during the quarter. So it's a record of expenditures for those individuals.

It's an important data source because, unlike the CMS-64 that I just described, which only provides state-level spending, the MSIS provides person-level enrollment and spending. What this means is that while the CMS-64 can tell you how much was spent on a particular type of service -- for example, physician care -- the MSIS can tell you how many enrollees received that service, how much was spent on the average user, which high-cost users account for most of the spending, and other details about the individual enrollees who receive their service, such as how they arrived at the Medicaid program, their age, race, sex, and other demographic characteristics.

Penny did touch on this, but one thing I do want to mention is the distinction between Medicaid and CHIP in the MSIS. As you know, states can operate their CHIP programs as a Medicaid expansion, a separate stand-alone program, or a combination of both. And the reporting of separate CHIP enrollees is voluntary in MSIS, so it's

important to note that MSIS does not provide a complete picture of CHIP enrollment. And this leads me to the last data source that I'm going to describe, which is the SEDS.

SEDS stands for Statistical Enrollment Data System, and the SEDS is a fairly basic data source because it only provides aggregate statistics, but it's the only federal administrative data source that gives the complete picture of enrollment across all types of CHIP programs. And as you can see on the slide, enrollment in the SEDS can be broken out by income, and as of fiscal year 2008, the SEDS shows that there were 7.4 million children enrolled in CHIP, and about 90 percent of those children had incomes at or below 200 percent of the federal poverty line. And this is true even though Jenny mentioned earlier that many states currently have maximum eligibility thresholds for CHIP above 200 percent of poverty. It's still serving a fairly low-income population for the most part right now.

So now that we have some background, some of the key federal administrative data sources that we use, I want to give some examples of how they're used for research and policy analysis.

One use is in projections of enrollment and

expenditures under current law and under alternative proposals, and these are typically made by federal agencies, including CMS and the Congressional Budget Office. Historical trends in the data are important factors in developing these projections.

Federal administrative data are also used to examine factors that account for Medicaid spending growth. For example, recent work has found that acute-care services such as hospital and physician care made up half or more of Medicaid spending growth over much of the last decade. Long-term care made up a somewhat smaller share depending on the year between 10 and 40 percent. But, again, that's the sort of information we can get from the data.

Another use relates to quality and outcomes. For example, it's possible to examine whether enrollees are receiving recommended care such as well-child visits by various age groups. And you can also look at patterns of use among subgroups of interest, such as foster care children where there's been sort of a wide variation in utilization of services across states.

Administrative data have also been linked with surveys and other administrative data sources to provide a

richer picture of the Medicaid and CHIP populations. For example, you might recall from MACPAC's September meeting that MedPAC has been analyzing linked Medicare and Medicaid data files to get a more complete picture of spending on individuals who are dually enrolled in both programs and who are particularly high-cost enrollees in many cases.

So although this presentation focuses on federal administrative data which allow us to examine Medicaid and CHIP at a national level and across states, we do recognize, as has been discussed earlier, that states collect and use their own administrative data to manage these programs on the ground and to conduct state-specific analyses. I also want to point out that some states are moving beyond Medicaid and CHIP to develop all-payer databases that provide some context with poverty insurers and other payers to sort of put Medicaid in context and bring it out of the silo that we sometimes keep it in.

That being said, federal sources on Medicaid and CHIP are also important because they provide some standardization for a subset of the voluminous Medicaid and CHIP administrative data that are collected by the states, so they do have some value. I'll talk a little bit more

about our plans to look at the state administrative data later on.

Now that you've been sold on the wonders of the federal administrative data, I'll talk about some areas where gaps have been identified, and the first managed care. I don't want to spend a lot of time on this. It has come up repeatedly today and during our September meeting, but what I do want to point out is that a recent report from the Health and Human Services Office of Inspector General found that all states with capitated managed care arrangements do collect this encounter data from their managed care organizations, and many of them are using it for quality assurance, for rate setting, and for other purposes.

The issue that we have at the federal level is that some states are not able to report that or don't report their encounter data in the MSIS, and among those that do, as Penny mentioned, the quality is largely unknown, and this is an area that CMS is just beginning to explore. They plan to provide technical assistance to a subset of states, but right now participation in the project is voluntary and the time frame for collecting and validating the data from all states is unclear. And, again, this is an important policy

issue, bringing it back to why we care about this, because capitated managed care accounts for about two-thirds of Medicaid enrollment right now and almost a quarter of program spending, and that means we don't have detailed information on the services that are being used that make up a large chunk of the program.

As I mentioned earlier, MSIS is a powerful source of information because it provides person-level detail on people enrolled in Medicaid, including enrollees whose Medicaid coverage is funded with CHIP dollars. However, as you heard earlier, states are not currently required to report their separate CHIP enrollees in MSIS, and only about half do so right now.

The policy issue here is that we're not able to look at coverage transitions for children moving between Medicaid and separate CHIP programs, and sometimes there is difficulty navigated between those two when there are separate enrollment and application processes. We also can't look at service use, detailed service use for separate CHIP program enrollees, and this is of particular interest because there are often differences between the benefit packages that are offered to Medicaid and separate CHIP

enrollees, and we just don't have good information on the differences that those benefit packages make right now. However, managed care keeps coming up. Since most separate CHIP enrollees are in managed care, we also need encounter data for this purpose, so there's sort of a two-fold problem when it comes to separate CHIP programs.

Again, timeliness is a perennial concern when it comes to the federal administrative data, and in the absence of up-to-date federal data on enrollment, the Kaiser Commission has been collecting its own information from states for a number of years to try and get more up-to-date information.

I just want to note here that the aggregate expenditures that we get from the CMS-64 are pretty timely because they are the basis for federal reimbursement. States have an incentive to submit those claims and to get paid pretty quickly, so those are available with just a lag of a few months. And MSIS takes longer, and on the slide here I have that only 13 states have complete data for fiscal year 2009. That refers to the number of states that are available online right now. As Penny mentioned, there are about 30 or so in total that have complete data, but it

takes some time to get those out for public consumption. So there's even differences in sort of when CMS has it, when it's available more widely, and when we can use that information.

The consistency issue, Penny mentioned sort of different versions of the truth. This is the final issue I'll deal with. The CMS-64, the MSIS, and the SEDS are all compiled independently to serve different purposes, so we would never expect them to match perfectly. But it's still important to understand and acknowledge how these differ so that when we're reporting information we can have a better understanding of what it does or doesn't represent.

For example, we know that expenditures in the MSIS are consistently below those that are reported in the CMS-64 data, even after adjusting for differences in scope and design. There are some state outliers that you can see here on the slide, but it's not entirely clear why this difference occurs, and we're hoping to dig into this a bit more to understand how it might affect the way that MACPAC decides to report the expenditure data from one source or another. I know that Kaiser has done some recent work where they try and match totals from the MSIS to the 64 so that we

have a better sense of what the spending picture is. So I think that's something MACPAC has to think about.

The policy issue here is that inconsistencies in the data make it a difficult to say with confidence that spending or other differences that we observe across states are really due to differences in their programs rather than differences in how they report the data, and that's an important issue for us because if we're looking at policies, we want to know that it's a real difference and not just an artifact of the information that we have about those policies.

I really have jogged through this. Okay.

A main goal of this presentation was to get us all on the same page regarding the content of the data sources that MACPAC will be using on a regular basis, but we're going to continue to explore areas for improvement in the CMS-64, the MSIS, and the SEDS data, and we'll continue to communicate with CMS about the initiatives that they have underway because they are looking for our input and our ability to convene outside folks and give them ideas on how to go forward.

We're also going to provide case studies on areas

where the data could inform key policy issues in Medicaid and CHIP. For example, I'll talk about how we plan to look at primary care spending in the session that follows this one using the MAX data that Penny explains is derived from the MSIS data.

We'll also look at additional federal administrative data sources, including those that provide information on state program characteristics, such as eligibility levels, covered benefits, and the use of waivers, because this information provides important context for the statistics that we put out. We need to understand why some of these numbers vary across states, and it's often because of differing program designs.

As I mentioned, we're going to consider how MACPAC could collaborate with or serve as a resource for users of state administrative data because we know there is a lot of activity at the state level and we hope that we could play a role in convening folks and sharing information with each other and perhaps with CMS.

As others have mentioned during the access and the early-warning system presentations, we're also going to look at national and state surveys that complement the data that

are available from administrative sources, and we look forward to any feedback or suggestions you might have for moving forward on these issues.

Thank you.

CHAIR ROWLAND: Clearly in our efforts to develop an early-warning system, to use data that's two years old to be a warning is a problem, so you can see that we do have some issues there.

COMMISSIONER HOYT: I had a couple of questions I would have asked Penny, but it sounded like she was pretty short on time. Do we know who's on MACBIS?

MS. GRADY: Within CMS do you mean?

COMMISSIONER HOYT: Yes. Is it only within CMS?

MS. GRADY: It's an internal working group that they've put together to sort of survey themselves internally.

COMMISSIONER HOYT: Would it be possible for us to request we have somebody audit that class or sit in, somebody like --

[Laughter.]

COMMISSIONER HOYT: Somebody like April.

MS. GRADY: I think from my understanding -- and

we can follow up with Penny on this -- that they are sort of at an end stage, that that council has been meeting for a while now, and they're at a point where they're ready to make some decisions about moving forward. But I think we could ask, you know, whether there's any way that we could play a role in that process.

COMMISSIONER HOYT: Another question. I'll admit I may not be totally current on 64s anymore, but in a prior life many moons ago, I did spend countless frustrating hours going through those forms across several states and just ended in complete frustration how inconsistent they were. And I don't know if this has been changed or not. I mean, some of the things that were fundamentally different were some states -- most states did it on a cash basis, and there was apparently no standards or rules about what you included or charged to specific quarters. It did have to tie back in some way to an audit, but it just ruined any consistency of trying to figure out what exact costs were in and which programmatic changes were reflected. The head count information that was in there didn't tie to anything. There were other forms that had -- in fact, then it was AFDC, but supposedly the same head counts, no connection. The people

or departments that prepared it, just all over the map as to who was doing it and how much attention to detail they spent. You can just go on and on about that.

So, I mean, if I was queen for a day, that would be something where I'd try to establish some standards or rules about how just that form was done. And I know that -- I was just going to use it in the rudimentary sense to check some basic high-level data, but you could not do it. It was just absolutely frustrating.

MS. GRADY: I can't promise that it's much different today. One of the things, as I mentioned, there has been some attempt to reconcile the 64 data, which, as you mentioned, are sort of high-level aggregate expenditures for broad categories of service, with the more detailed information that's in the MSIS to try and get a sense of sort of what's being reported and when. And those things, they don't match up very well necessarily.

One thing I do want to follow up with folks at the Kaiser Commission and the Urban Institute who have looked at this is to see sort of where the discrepancies are so that when we're reporting information from the MSIS we have a god idea of where the state anomalies are and where we should be

looking at the data with a sort of skeptical eye in our analyses of particular types of service or particular types of spending.

The other thing I would say in response to your comment about the head counts, you know, that's sort of totally disconnected from the spending reports. I don't believe there is even enrollment on the 64 spending forms right now. So what that means is that the enrollment is just sort of on a whole separate track.

COMMISSIONER HOYT: Okay. I've already exceeded my quota. Maybe this should be in the parking lot. I just had a thought that kind of overlaps the last three presentations we had. We've talked before about integration or coordination of programs, like physical health, behavioral health, Medicare, Medicaid. I've heard Medicaid directors talk about concern they've got in the brave new world when people move below and above the eligibility line, maybe out onto the exchange. I couldn't help but think about CHIP programs and Medicaid.

Have we observed or given any thought to states that made different choices about how to set up the CHIP program? Is there one way that seems better than others

that would improve administrative efficiency, higher quality, improve access perhaps as well?

CHAIR ROWLAND: That's something we can certainly look at and, as part of our CHIP mandate, probably should look at.

The other thing that -- you know, we've talked about the inconsistencies. This is within the data that's collected within the Medicaid program, and then when you try and reconcile that with survey data or with the census data, you have yet another set of discrepancies that are pretty hard to deal with.

MS. GRADY: And as I did mention, the linking of the survey and the administrative data has tried to get at that question of how many people are enrolled in Medicaid when you look at the surveys versus the administrative data. There's been a lot of work by the Census Bureau and other people on that issue.

COMMISSIONER COHEN: This will reflect some ignorance, I think, this question. But it seems like all the data sources that you're talking about, the administrative data is all about what was spent and how it was spent. Penny mentioned that in the sort of perfect,

idealized world in the future they'll have some sort of data repository -- I'm going to use all these words wrong, but, you know, some sort of data repository for operational data, which I think is largely administrative data, and then program data, which is sort of like policies -- payment rates, payment methodologies. Is that all the stuff that sits only on paper now? And that's why it's impossible, like if you're not a researcher but you're just trying to get a general sense of like, well, gee, you know, where do my state's payment rates, premiums that we pay to Medicare organizations or anything like that compare to maybe some similar Medicaid program? I understand every program has different benefits and, you know, it's hard to do a direct apples-to-apples comparison. But there's really no place on the planet to date to be able to do that, whether incomplete or frustrating or not, it just doesn't exist. Is that correct?

MS. GRADY: Yes.

[Laughter.]

MS. GRADY: And I'll qualify that. I think there's two issues, and I think you're right in describing sort of the program/policy information is the stuff that

resides on paper, if it resides at all. So one example is payment rates. CMS, there's largely no collection of information about what states are paying providers. I believe there are some exceptions for institutional -- certain hospital and other providers. They do collect that information. But physicians, other practitioners may not even reside on paper at CMS, so that's something that just lives at the state level.

For the things that do reside on paper, as Penny mentioned, there has been an effort to extract some information and make it electronic, but it's very difficult right now to get that information in a consistent and accessible format.

CHAIR ROWLAND: The government doesn't always collect all of this, but others who think this information is important have separately invested in trying to do surveys of the provider community to find out what the payment rates are. So some of the data that you'll see later comes from a study the Urban Institute does of interviewing states to find out what their payment rates are, or going to the states and trying to collect information on what their eligibility levels are and their

different eligibility barriers or enrollment easements that they have so that we can look at how the income eligibility is determined.

So one of the problems here is that the government doesn't always have -- you expect that CMS would have all this information, and then if you're trying to answer some policy questions, you discover that they don't. And right now many of these -- the information that we have on many of these issues has come from individually financed surveys, which are not necessarily annual and are often things that you would think the government would already be collecting that they're not. And now Lu is going to talk. Government is trying to add this into their health care data.

EXECUTIVE DIRECTOR ZAWISTOWICH: They are trying to add it into the health care data. But what I think is very interesting when -- as part of the ACA, the Office of Consumer Information and Insurance Oversight was standing up the web portal, and they wanted information on the Medicaid program, they couldn't go to the state plan amendments. They had to do an independent survey in order to get those data. So it's just an example of how it's just not collected, has never been routinely collected, and there's a

real need in this area -- and a lot of inconsistency.

COMMISSIONER COHEN: And just sort of to follow up on this, and it may be a bit of a naive question, more of a thought question than you-have-to-have-an-answer-this-moment question, but obviously in some areas there is sensitivity because the data is proprietary or competitive or something like that. But I assume there's other sensitivities as well. So, anyway, I just want to sort of flag for us we should think through maybe to some extent, you know, how much is there actual resistance to getting this in electronic form that's not just about burden and, you know, sort of how that should inform our thinking about recommendations.

VICE CHAIR SUNDWALL: I feel like it's my responsibility as a state health official to just say enough is enough. When I saw that one slide with the multiple reporting things, it just brings back daily reminders that we are surveyed to death. We have so many forms to fill out. We have so much accountability. And so I think this Commission could do a great service if we could promote what Penny Thompson was talking about, a more simplified system of reporting the information that's essential. But the

complexity -- and then it's disheartening to hear the variation, questions on the reliability, and then to hear several others saying, well, we need this and this and that and that. If they're going to need more data elements, then can we somehow recommend it be woven into what we must provide instead of yet another system or another form?

So I guess this is a generic comment, but it really, I think, would be shared by most of my colleagues at the states who really do feel like it's a costly, time-consuming burden to provide information all the time.

CHAIR ROWLAND: We do have to remember that there are two purposes of collecting data. One is to figure out what's going on in the program, but the other one is for the federal government to figure out what it needs to pay out to the states. And so there clearly has to be accountability and that the 64 has been primarily that tool, but it doesn't provide much reliable trackable information because it also changes every time there's a disallowance or another change as well. So those are twin goals that we have to keep in mind.

COMMISSIONER MOORE: It seems to me that the only way you can hope for more standardization and uniformity in

any of these is for there to be some significant or at least some incentives -- money and certainly a lot of technical help -- for the federal government to do a lot of things. And it seems to me that we could certainly put some of those ideas on the table for how to bring greater standardization and more accountability -- it's not really accountability, but more uniformity into this system at a time when states have got lots of other things on their plates. But surely we should be able to walk through how to redesign this so that you put everything in one place and you don't have 16, 17, 25, 35 reports.

But, you know, I think that we as a Commission and the staff need to be keeping this on the front of the agenda as we're doing other more substantive things, because this underlies so much.

CHAIR ROWLAND: And one of the other issues we need to look at is what the federal versus state match is, because for administrative data it has not been the same as for medical services.

VICE CHAIR SUNDWALL: How has it been ? Is it 90-10 or 50-50?

CHAIR ROWLAND: It has been 90-10 for some

systems, and then it's gone to 50-50 and doesn't vary by the income of the state like the normal match.

COMMISSIONER HOYT: One other thing that I think would be really helpful and not that hard to do that I still don't -- I don't know any source for this. In the contracting checklist maybe that CMS uses, or somewhere -- we talked on and on about how many people are in managed care contracts and the mystery of the black box and what am I paying for. If we could just get each state to disclose behavioral health is carved out, or it's in, pharmacy is in or it's out, dental services are in or they're out. I could give you like ten basic things to just list off right away that would tell me volumes about the managed care data. The CHIP population, are they embedded in the TANF or is that a whole separate, someplace else? If you just could answer like 10, 12 questions like that, you could blow a lot of smoke away from some of the comparisons at least between state to state. And I think that at least would be a starting point that wouldn't be that hard to do that would provide some clarity.

CHAIR ROWLAND: Okay.

MS. GRADY: I think that's a good idea, and I

would just point out that CMS does have managed care enrolment reports that might have some of that information that we could make use of when we're doing state comparisons and looking at the managed care data.

CHAIR ROWLAND: Okay, and on that note, I think we'll ask Nikki to come join April, and we'll move on to looking at yet another issue of how we review the increase in Medicaid payments to physicians for primary care that's embodied in the Accountable Care Act and what some of the literature and research on that will show.

CHAIR ROWLAND: And, April, you are going to start, correct? Welcome to Nikki Highsmith, who is with the Center for Health Care Strategies. Thank you for coming. We know April.

REVIEW OF THE INCREASE IN MEDICAID PAYMENTS TO PHYSICIANS FOR PRIMARY CARE

* MS. GRADY: Yes. I am happy to be back here to talk to you about primary care.

[Laughter.]

MS. GRADY: As I mentioned in the session --

CHAIR ROWLAND: Or willing to return.

[Laughter.]

MS. GRADY: Still here. As I mentioned in the session that just ended, this is an area where we plan to make use of administrative data to look at State variation, and I'll talk about that at the end of my presentation. But first, I'm going to review what we do know about current Medicaid payment rates, and I'll describe the primary care increase that was included in the Affordable Care Act.

As you heard from some of the presenters at our September meeting, low payment rates are the most frequently cited reason for physicians not participating in the Medicaid program, but other factors, such as administrative burden, play an important role, as well. Recent work indicates that Medicaid physician payment rates were lower than Medicare in most States under fee-for-service programs in 2008, and among primary care services that were surveyed, Medicaid payment rates were about 66 percent of Medicare rates, on average. This is a bit lower than the average for all of the services that were surveyed, where Medicaid payment rates were about 72 percent of Medicare, on average.

While we do have some information on fee-for-service payment rates, we know a lot less about the payment rates and methodologies that are being used by managed care

organizations to reimburse providers for the care delivered to their Medicaid enrollees. However, anecdotal evidence does suggest that many of these managed care organizations reimburse the providers for Medicaid services at or near Medicaid fee-for-service rates, and that is sometimes a necessity simply because of the way the capitation rates are developed by the State. They assume, in many cases, fee-for-service reimbursement rates. This is something we'll be looking at further in our work on managed care. Lois Simon is going to talk to you a little bit more about that topic later on.

In light of historical and future concerns about access to care for Medicaid enrollees, the Affordable Care Act requires States to increase Medicaid payment rates for primary care. Specifically, it requires States to provide Medicaid payment at or above Medicare rates. They have to provide that payment for certain primary care services that are furnished in 2013 and 2014. And that payment rate applies to physicians with a primary specialty designation of family, general internal, or pediatric medicine. So it does not apply -- ooh, okay. I'll just keep going while we get that fixed.

The payment rate increase is required under both fee-for-service and managed care. We'll talk about some of the potential implementation issues surrounding that later on.

States are going to receive 100 percent Federal reimbursement for expenditures that are attributable to the amount by which the Medicare payment rate exceeds the Medicaid payment rate that they had in place as of July 1, 2009. So this rate increase is not going to cost the States anything for the two years that it is in effect. There are questions about whether it will continue after that, but at the moment, there is only Federal funding for this in 2013 and 2014, and it is only a requirement in 2013 and 2014.

The estimated Federal cost of this policy is somewhere between $8 and about $11 billion, depending on whether you look at the Congressional Budget Office or the CMS estimate.

I just want to note here that primary care can be defined in many ways, but here, we're talking about a specific set of services that were defined in the Affordable Care Act. The focus is on physicians, because as I described on the previous slide, the primary care increase

in the ACA only applies to physicians with a specialty designation of family, general internal, or pediatric medicine.

In addition to the fact that the ACA only applies to physicians -- the ACA increase only applies to physicians -- I just want to point out that information on non-physician providers, such as nurse practitioners and physician assistants, is a bit harder to come by and something that we're going to explore in our data analysis, as well.

Getting to the specifics of the primary care services that are covered, for purposes of the Medicaid payment rate increase in the ACA, primary care is defined as evaluation and management of services that are covered under the Medicare program and certain services that are related to the administration of immunizations. And although these evaluation and management codes and services are listed in the Medicare Physician Fee Schedule, it's important to point out that some of them are not covered by Medicare and some of them are not used for Medicare payment. So it's unclear at this point whether those services would be excluded for purposes of the Medicaid payment increase, and that's

something that the CMS will have to put out guidance on.

Here, I just wanted to give some examples of the kinds of services that fall within the range of procedure codes that define evaluation and management, and it's a fairly broad range. Some of the examples include office visits, hospital care, emergency department visits, and preventive visits and counseling. But again note that many of the preventive service codes are not covered by Medicare, so there's some question about whether the Medicaid payment increase will apply.

And I would just refer you back to your briefing materials, where we provided a more comprehensive and detailed list of the evaluation and management services as they appear in the Medicare Physician Fee Schedule, if you want to get a more detailed look at those.

So not surprisingly, there are many policy and technical questions that are being raised by this provision, and I won't get into these now because Nikki is going to discuss many of them in her presentation.

Although we do know that most States have Medicaid physician payment rates that are well below Medicare rates, we don't necessarily have good State-level information on

the total dollar amount that States are spending. I mentioned earlier that we do have a Federal estimate of the national cost, but we don't have good information on the distribution across States. So in order to provide a lay of the land on this primary care issue, the MACPAC staff are planning to analyze the MAX data that you've heard mentioned, which are derived from the person-level claims information, to look at spending on these primary care services, at least as they existed two years ago, I guess, just to get a lay of the land.

To the extent possible, we're going to use the data to examine State-level fee-for-service spending on these primary care codes in the aggregate and across different types of services, and we're also going to look at physicians and non-physicians to the extent possible. We're also going to consider whether the fee-for-service results could give us some insight onto managed care, since as we mentioned earlier there's some anecdotal information that they're paying rates that are close to fee-for-service, and we look forward to hearing your thoughts on that analysis as we develop it further.

Right now, I'd like to turn the discussion over to

Nikki Highsmith from the Center for Health Care Strategies, who is going to talk about the work that CHCS is planning to address some of the thorny questions raised by the primary care increase.

* MS. HIGHSMITH: Good afternoon. Thank you for the invitation to present today. My name is Nikki Highsmith and I am a Senior Vice President at the Center for Health Care Strategies, and we worry about quality and equity in the Medicaid population, particularly for complex populations.

I'm going to talk to you a little bit today more as a discussion. I think I can present a lot of questions and not necessarily a whole lot of answers, but a process that we're going to go through, hopefully in collaboration with MACPAC and CMS and others about ways to address what we're now calling the PCP bump. It's good shorthand.

So just to sort of contextualize this for a moment, the PCP bump is one of those provisions in ACA that I think is very important to look at in the context of the entire bill. Most of the provisions related to obviously expansion and coverage are mandatory, obviously, and most of the provisions related to delivery system redesign and how we build a better and more efficient delivery system are

voluntary. And this is one of the few areas within the Medicaid provisions of ACA where we have a mandatory provision to raise provider rates. So it's not voluntary, it is mandatory across States, and it's funded. As you know, many of the provisions in ACA related to delivery system redesign are subject to the appropriations process. So it's an opportunity, and I think as a result of that, people are expecting a lot out of it because it is funded and it is mandatory and so it's starting to become the little Christmas tree of expectations.

So I will talk to you a little bit about what we have done to date, how the work that CHFC is doing can inform the work that MACPAC needs to do. We've already been talking very closely with April. And probably more than anything, just raise a series of questions that we're trying to address through the process that we're going through.

So I'm going to quickly go through my slides. This is a map of the U.S. in terms of health profession shortage areas by county. You obviously see that there's lots of red on here, which shows full HPSA areas. I will say just two seconds on sort of the primary care demand and supply issues. We do know there's a shortage and

maldistribution of primary care providers and others across the country. We also know that there is a rise in preventive services, a rise in chronic care needs arising from the aging of the population, and this is creating sort of a supply shortage across the country.

In terms of demand, I think one of the things that we worry about in the Medicaid program is the build-up of the exchange, and when we think of demand for primary care services, is Medicaid going to be competing with the exchange to bring on these new providers into its network? And so this -- and we're also looking at new advanced primary care models within primary care and how does the rate increase impact our ability to advance those new primary care models.

So as we think about the PCP bump, it's in this larger context, obviously, of primary care shortage and primary care redesign and certainly the funding that's available and the interface between Medicaid and the exchange. So I think it raises a lot of very interesting policy and design issues.

So why does CHCS care about this issue? We wake up as you do every night worrying about the 60 million

people on Medicaid and providing high quality and efficient services to those individuals. We also spend a lot of time helping States implement Federal policy, and so we do a lot of hands-on work with States and MCOs and, increasingly, provider organizations across the country.

So I'm not going to go into a lot of detail here, but we're working with a national survey of about 200 primary care physicians and practices around the country around their capacity to do medical home and what do we really know about national capacity for medical home work. We are working with States across the country on supporting advanced models of primary care that include both payment and practice redesign elements. We are certainly working in this project around maximizing the benefits of the primary care increase. And worrying a lot about the number of small physician practices that Medicaid supports around the country and their ability to practice in this new paradigm and how we support small, independent practices by providing shared resources to them like nurse care managers, like social workers, like community health teams, like health information technology, to be able to network many of those isolated shared practices. So this work fits very nicely

within a broader context of work that we're doing.

So we do have some funding from the Commonwealth Fund. As most of you know, CHCS is almost 100 percent philanthropically funded. We get most of our funding from the Commonwealth Fund, Robert Wood Johnson Foundation, and do philanthropically supported projects. So we do have funding to convene key stakeholders around sort of major policy and technical issues associated with this provision. I've listed the types of individuals that we want to work with. We're working closely with CMS, obviously, closely with the State, the researchers, mentioned Steve Zuckerman's work today, and others to try to understand and get a context of what are the big issues that we're going to discuss.

And our goal here is to help develop a road map for States to help implement it, and also to feed information to CMS about the major policy consideration and design issues that they're going to need to figure out.

But there's a lot of different expectations, I think, that different people have around the bump. So from the Commonwealth Fund, they're looking at how Medicaid can pay at parity with Medicare and use that as a way to become

a high-performing health system. They're also very interested in how Medicaid could use this as an opportunity to create additional quality and access requirements from its physician community and whether they can standardize those requirements with other purchasers, and so there's a standardization discussion. Certainly, CMS is really worried about, like, how are we going to assure that the right funds go to the right providers for the right services, and that's all the issues that April was bringing up in terms of what we know and don't know about what States currently spend.

We're working very closely with Mary Kennedy and her staff -- I know Asher and Jenny are here -- to begin to raise issues with CMS about what States can and can't currently do in terms of what we know about what the States are providing.

And finally, I think from the State perspective, it's so -- here I am, a State Medicaid Director. I'm going out there to recruit new people for my network because I have 15 to 20 million new people coming on the Medicaid program and I go out to my physician community and say, I can pay you at Medicare rates at parity for two years, and

right when I really need you for the expansion population, I am going to cut you off. And so I think this question of how do we think about the sustainability of a rate increase in the Medicaid program for primary care after 2014 is a big one that States are currently considering. Do we think we can actually show a return on investment from having additional PCPs in the program and show reductions in the ER and hospitalizations? So they're already thinking creatively about the sustainability issue.

So the kind of top questions or issues that we're going to get into are the following. So the first is this whole idea of leveraging the increase to expand, and maybe in some cases maintain the network of providers that we have within Medicaid. Are the rate increases enough? Certainly we know that that is a major factor in terms of provider participation, but it's not the only factor. Administrative burden and timeliness of payment can also be issues. And we also know that this bump won't impact all types of primary care providers, and so, again, sort of thinking about managing expectations in terms of what the outcomes are going to be.

The second is sustaining the increase beyond 2014.

States are already thinking about this. Can I show an ROI? Can I use the enhanced funding for the new eligibles to sustain an increase that way? Certainly, States are already trying to put their messaging together for the provider community.

Again, can this make Medicaid a better business partner? I think one of the things that is very important to think about is to really continue the transformation of delinking Medicaid from sort of a welfare-based system, and as Medicaid becomes a health care purchaser for 80 million people, how does it function and act differently as an administrator of that program? And so being a better business partner in terms of timeliness of payment and the application process in many States. And so, again, using this opportunity to leverage other efficiencies.

Linking the increased fees to access and quality standards, and this has come up several times in our discussions across the country. In some States that are paying at pretty low Medicare [sic] rates right now, there will be a significant infusion of payment to primary care providers. Do they have some expectations or standards that they set around access and/or quality and/or the patient

centered medical home?

April already mentioned this. How do we ultimately define primary care provider, and this is the work that CMS will be doing, and currently, it doesn't include nurse practitioners and physician assistants. Certainly there's the discussion around hospital outpatient facilities. Many of the E&M codes are codes for provision of services in hospital outpatient departments, and so what's the connection there?

And, as April already said, assessing those codes that are applicable for the bump, the whole issue of sort of what's in the Medicare fee-for-service schedule versus what's a covered service, and again going back to many of the preventive services and the EPSDT benefit and how we think about primary care and EPSDT.

Then the last three issues, understanding what States are paying as of July 2009, and April raised this in her discussion about data sources. We do have the survey that Steve Zuckerman did at Urban. I was on a call yesterday with about ten States where we were talking about this issue. We listed all the rates that were in that paper and all of them said, well, we don't pay that now. We pay

this. So just the timeliness of the information. And also, it's going to need to be as of July 2009, and not all States keep historical data on what their rates have been, and obviously the issue about what managed care is paying for primary care rates is something that we don't know a lot about and we're going to try to figure out different ways of accessing that information. Can we access it from the encounter data? Do we do surveys, things like that.

Implementation time frame -- when we first started this discussion with Mary Kennedy at CMS, on the one hand, of all the things that CMS has to do in the next two years -- this is 2013 -- you would think it is not high on the list. But those of us who have done provider contracting at a health plan level and/or done rate negotiations between States and managed care organizations and/or back up what information that States will need to provide to CMS in terms of State plan amendments, this is going to take a little bit of time. So the sooner that we can help raise the key policy issues and help CMS and the States and the dialogue, the earlier we're going to be able to get guidance for the long term.

And then the last one is just really on evaluating

the effectiveness. I think for the $8 to $11 that is being spent at the Federal level, how do we be able to assess whether we are having an impact, both in terms of access and quality?

So this is just to close with. The answer to this question a few years ago, even a decade ago, maybe you wouldn't have found one in the opera house, and many times these days there are -- we have worked really, really hard over the past decade as States have become very good purchasers of health care to build an adequate supply and network of physicians, and I think we are all sort of holding our breath to understand the impact of this provision and our kind of competition with the exchange and whether we can continue to have providers that will accept Medicaid patients in the house.

So I turn it over to Diane.

CHAIR ROWLAND: Questions? Mark?

COMMISSIONER HOYT: OB/GYNs, are they primary care providers for women when they're pregnant?

MS. GRADY: The law refers to primary specialty designation and it doesn't specify a source for that designation, so that's a question that CMS is going to have

to answer, what's the source for the primary specialty designation of a provider. But right now, OB/GYNs are not listed.

COMMISSIONER HOYT: Because most States qualify them as being a PCP for pregnant women. It's probably the only doctor she sees, so it just begs the question of all the prenatal care or how the State even pays for that. What's the bar, then? What are they going to compare to? On the Medicare side --

CHAIR ROWLAND: Medicare doesn't do much of that.

MS. GRADY: Yes. Medicare does actually --

CHAIR ROWLAND: Because of the disability population.

MS. GRADY: Yes. And so there are actually obstetric and other services listed in the Medicare Physician Fee Schedule, and apparently those are updated on a regular basis, not because Medicare necessarily uses those codes, but because other payers have adopted the Medicare Physician Fee Schedule, the committee that updates the codes does look at the non-Medicare covered services, as well.

VICE CHAIR SUNDWALL: Well, in our State, the disparity between primary care and Medicaid and Medicare

rates is much greater than what we pay our OBs. In other words, they're paid a fixed amount. It's a capitated rate, but it's not the barrier for OBs.

Let me just make one comment as a primary care physician who still sees patients a half-day a week in the clinic. In some ways, I can just -- I'm going back to my days when I was a Hill staffer. This is a provision, it seems to me, it was done late at night and compromised. The heart is in the right place, but the incentive is really modest. I don't know that all of the questions you raise you can answer, but they're all legitimate, about whether or not it'll make a return on the investment. But the idea that it's two years only is ludicrous. I mean, I guess that they calculated it'll be, even at two years, $8 to $11 billion and so they cut it off at that. But I don't know if my family physician colleague shares my point of view, but I just think this is almost too modest to make much of a difference. We'll see.

COMMISSIONER WALDREN: Yes. We have done some analysis of that and it's about three, five, and seven percent, on average, in 2010, 2011, and 2012 in regards to the revenue. Now, that's not income. That's revenue coming

in. And the average income from a revenue perspective from Medicaid in family physicians is about $38,000. So take $38,000 and take it times three percent, five percent, and seven percent. So it's not a lot, but I think it will make some difference.

VICE CHAIR SUNDWALL: Depending on the volume.

MR. WINTER: Well, and it depends on what State. So, like California, which is at, what, 0.47, again, based on if that data is actually correct or not, then you're looking at 11, 15, 18 percent increases and I think that's something that will make a difference.

CHAIR ROWLAND: There are some States that actually pay at Medicare rates already, too --

MS. HIGHSMITH: Oklahoma, North Carolina. Those States are paying --

MS. GRADY: I think Massachusetts is up there now, as well.

MS. HIGHSMITH: California, New York, New Jersey were some of the States in the study that paid at the lowest. New York has done a significant amount of work over the last two years to raise their primary care rates, so they're higher than they were in the survey. New Jersey has

about 80 percent of their folks in managed care so that fee-for-service rate is not as applicable. But those are the types of questions.

David, I think one issue that we'll need to consider is can we maintain the network? Is maintaining the network an actual positive outcome as a result of this, as opposed to just sort of an expansion, and I think the question of maintaining who we have in the program by paying them better, we may not get new physicians in to participate, but if we can maintain our current level, we're probably doing a good job.

CHAIR ROWLAND: First, Donna.

COMMISSIONER CHECKETT: I have a slightly different tact I'd like to just throw out as an observation and comment based on a lot of experience with Medicaid managed care, is that I think managed care companies are very used to working with States in all kinds of weird payment arrangements. We pay wrap-arounds, you know, to FQHCs. We have the State pay the wrap-around. We pay rebates. We collect rebates. The State pays the rebate. We carve things out. We get increases for dental fees. They have to be passed through, but they have to go through

the MCO. We have to show the State auditor that we've paid it. I mean, I don't think that this is going to be a single bit of an issue for MCOs other than for the States and the MCOs and then each State to figure out how they're going to do it.

And so it's my own opinion. I see nodding from Richard and I know Mark has many years of experience. Just with enough issues and concerns out there, I don't want that to become a bugaboo it isn't. I think just tell them how to figure it out and it'll get figured out.

I think the greater thing -- my other opinion -- I'm on a roll --

[Laughter.]

COMMISSIONER CHECKETT: -- is that, for the most part, primary care physicians respond extremely well to Medicaid. Lots of them see a little bit or a lot, and I think if anything, we'll see more people participating in the program. The real thing that's going to show up is that we still aren't addressing the specialists who, frankly, when you look at most Medicaid fee schedules across the country and the MCO payment rates are just tracking right along with it, those primary care rates and OB, global and

all that, they're not all that bad in most cases. It's the specialty care that really suffers, especially in comparison to the type of compensation specialists can get from other insurance and other sources of payment, so --

CHAIR ROWLAND: It's especially true on mental health.

COMMISSIONER CHECKETT: Yes, exactly. Some observations.

COMMISSIONER ROGERS: I just have a quick question, and that is in terms of nurse practitioners. You know, if you work in a rural area where you're the primary care provider, but you can't be listed as a primary care provider, it really becomes an issue to us. I mean, you have a provider number, but you can't be, even if you're F&P, you can't be a primary care provider. In rural communities where there are no physicians, real small rural communities where there are no physicians, it becomes an issue. It becomes a hassle, to tell you the truth.

MS. HIGHSMITH: So two issues there. I think this is a key area that CMS will need to think about in terms of providing guidance to States. Even if they're not included in the definition of a primary care provider, most States

set their rates for nurse practitioners off of the primary care rate. So if the primary care rate goes up and they're getting 85 percent of that rate, they will see some increases, but it won't be as big as if they were actually qualified as a primary care provider. Does that make sense? So I think that some benefits might accrue, but I think this is one key policy area that CMS is definitely addressing.

CHAIR ROWLAND: Thank you very much. Oh, did you want to ask a question?

COMMISSIONER RILEY: Nikki, before you -- can I just -- sorry. I think the CHCS work is great and really focused, but I had one concern about your characterization of competition. You said a couple times, competition between Medicaid and the exchange, and I think that is a warning for us on MACPAC. It's a new world and we need to think, I think, about not competition, but integration and more collaboration, because if we don't, we're really at peril. And I think when you think about -- if you think about zero to 400 percent of poverty, they're all in subsidies. The zero to 138 are the Medicaid people. It doesn't make any difference. An exchange could be a marketplace if Medicaid was in it.

MS. HIGHSMITH: Medicaid is part of it.

COMMISSIONER RILEY: It would have a whole lot more clout.

MS. HIGHSMITH: And I would agree, and I think you have a subset of States out there that are thinking in that new paradigm, as Medicaid is part of the exchange and partnerships across -- you know, purchasing strategies. And then you do have a set of States that are thinking about it more in a -- not in a competitive way. That maybe is too strong a term. And so I think, again, the differentiation that we will see across States and their approaches is going to be pretty extreme.

COMMISSIONER RILEY: Thank you.

CHAIR ROWLAND: Okay. Now we'll go to Lois.

STAFF BRIEFING: OVERVIEW OF MANAGED CARE MODELS

* MS. SIMON: Hello again and good afternoon.

CHAIR ROWLAND: How do you like being the last session?

MS. SIMON: I know. First session, last session.

[Laughter.]

MS. SIMON: It is the end of the day. So this session is designed to provide you with a general

understanding of the basic structure of Medicaid and CHIP managed care. I will highlight some of the reasons why States assume managed care for their Medicaid and CHIP populations, discuss trends in the most common models of managed care, as well as some of the unique characteristics of Medicaid that can make managed care challenging for both States and plans. Again, I look forward to your input on this topic as we move forward with designing an agenda moving forward.

State rationales for pursuing managed care for their public programs are multiple. Back in the early days of managed care, many States initially pursued managed care with a goal of achieving savings. While evidence of sustained cost savings has been mixed, managed care provides States with some control and predictability over future costs, something that I think is especially important in times of budget constraints, which we are in now.

States also believe they gain control and accountability with managed care as well as can improve quality. The contractual obligations of MCOs require plans to have a strategy for providing quality care for its members, and compared with fee-for-service, it is easier to

devise models that measure, report, and monitor performance. Most States now require their plans to report some quality measures and many are also implementing pay-for-performance and quality incentive programs, which seem, as we heard today, to prove effective in getting plans to perform.

For the Medicaid population, unique provider competencies are needed and States can make contractual demands on participating plans, requiring them to meet minimum standards related to the adequacy of provider networks and provider credentialing, many of the things we heard today. And States can also require their plans to maintain certain appointment availability systems, consumer appeal structures, and have linguistic and competency expectations.

And lastly, States look to managed care to provide their enrolles a medical home. In fee-for-service, as we know, care can be fragmented and often there is no PCP guiding the member. With a guaranteed access to a PCP, enrollees have a health home that provides an opportunity for improved continuity and care coordination as well as it emphasizes prevention and early detection of health conditions.

So there are two basic types of managed care arrangements in Medicaid today, risk-based plans and primary care case management, or PCCMs. In risk-based models, MCOs are responsible for building a network of providers that meet certain access and capacity standards defined by the State. Plans are put at a financial risk, getting paid a capitated rate per member per month to provide a defined set of services. Typically, some benefits are carved out and are provided separately either through fee-for-service arrangements or directly by the State. The most common carve-outs are behavioral health, non-emergency transportation, and prescription drugs, but there is a considerable variation across States on what is in and what is out of a plan benefit package.

PCCMs are popular in many areas where risk-based models are just not feasible. They have been particularly successful in rural areas, where attracting and retaining both physicians and MCOs have been difficult. PCCM models ensure that Medicaid beneficiaries have access to a PCP who is responsible for approving and monitoring the care of the member, and the PCP is typically provided a small monthly fee for providing these additional services as well as being

paid on a fee-for-service basis for primary care.

Many States use both risk-based managed care and PCCMs in their programs. Often, the risk-based model operates in most of the State, especially in the urban areas, and the PCCM models are in the rural areas where there's little interest in a fully capitated program. And one good example of a hybrid program is Pennsylvania, which we heard about earlier today.

This chart shows that today, the Medicaid program seems relatively committed to managed care, as almost three-fourths of all Medicaid beneficiaries are in some form of managed care. While not shown on this chart, the trend towards managed care has been a steady increase since the late 1990s. In 1999, there were 18 million in managed care compared with 33 million Medicaid enrollees, or 71 percent of the population in 2008.

This chart also shows the role of risk-based plans. These arrangements have historically been and continue to be the most common model of managed care, and as of June 2008, almost half were enrolled in risk-based managed care.

This map shows the concentration of risk-based

models throughout the country. Risk-based models are in 34 States and the District of Columbia, and as you can see, are predominately along the West Coast and in many Northeastern States. In three States, Arizona, Tennessee, and Vermont, 75 percent or more of Medicaid enrollees are in risk models, and there are 22 States and D.C. where more than half of enrollees are in risk-based plans.

This map highlights the fact that some form of managed care is embraced by most every State in the country. All but two States, Wyoming and Alaska, use some form of managed care for their Medicaid programs. Forty-six States plus D.C. have 50 percent or more of their beneficiaries in managed care, and 24 States have 75 percent or more.

So comparing this map to the previous map -- on this map, the PCCM models are included -- one can see the predominance in the role that PCCMs play more in the middle of the country.

There are two types of Medicaid risk-based plans, commercial plans and Medicaid-dominated plans. Commercial plans are defined as plans where non-Medicaid enrollees make up at least 25 percent of total plan enrollment. Many commercial plans are multi-State plans that have created

Medicaid-only products that are separate from their commercial lines of business. And as its name indicates, Medicaid-dominated plans are those that focus on serving enrollees in Medicaid, CHIP, and other public insurance programs for low-income and vulnerable populations.

As you can see, a majority of enrollees are in plans that predominately serve Medicaid beneficiaries. In 2009, Medicaid-dominated plans covered 57 percent, or 13.8 million, of all beneficiaries enrolled in risk-based plans. And there are two types of Medicaid-dominant plans.

The first are provider-sponsored plans, and these are plans that tend to have a long history of serving low-income and vulnerable populations. Many are owned by safety net hospitals and/or health center systems.

And the second type of Medicaid-dominated plan is the for-profit plan that is often affiliated with a multi-State company and is publicly traded.

And over the past several years, there's been a lot of movement in the different types of participating plans. There's been growth in Medicaid-dominated plans and a decline in the number of commercial plans, and this is something that we want to look at further, kind of trying to

understand the market dynamics within the Medicaid managed care world.

CHIP programs. As April mentioned earlier, States were given the flexibility in the design of their CHIP programs in 1997, when the program was established. They could either expand their Medicaid program, create a separate CHIP program, or operate a combination of the two. Almost two-thirds of States have implemented their CHIP programs through a separate program, either alone or in combination with a Medicaid expansion. So the type of program that a CHIP enrollee is in kind of seems to vary what type of managed care they're in.

First of all, most CHIP programs rely heavily on managed care. Eighty-four percent of CHIP children are either in a capitated managed care program or a PCCM program. The beneficiaries in States with a separate program are more likely than those in States with a Medicaid expansion to be in risk-based managed care, 79 percent in separate programs versus 47 percent in a Medicaid expansion program.

And reliance on fee-for-service is also much more limited in the separate program. More than one-quarter of

those in Medicaid expansion programs receive care through fee-for-service compared with 11 percent in separate programs.

There's a growing interest among States to enroll populations beyond children and families into managed care. Individuals with chronic conditions and disabilities as well as dual eligibles are increasingly enrolling in risk-based plans, either voluntarily or are mandated to enroll. So when competition managed care is not feasible and also to better accommodate the needs of beneficiaries with chronic illness and disabilities, many States are experimenting with new programs that stress medical home and care coordination. These new designs strive to minimize the fragmentation of the fee-for-service system and ensure greater continuity of care and improved access.

Some States have established enhanced PCCMs. These programs typically manage chronic conditions through disease management or intensive care management. While some States target their enhanced PCCMs to individuals with specific conditions, others target individuals with multiple conditions.

Targeted case management is another option, and

it's one that often includes predictive modeling to identify at-risk populations and that employs disease-specific education and intensive case management for a specified beneficiary population.

And lastly, Medicaid Advantage Special Needs Plans, or SNPs, were introduced for dual eligibles as a way to better coordinate Medicare and Medicaid benefits.

Compared with commercial health insurance programs, managed care and Medicaid proves to be more complicated, complex, and challenging. First, Medicaid eligibility rules and enrollment processes can be extremely complicated when you're considering all of the various eligibility categories and the enrollment rules in each State. Medicaid serves many very different populations with very different needs, and while managed care has primarily served children and parents, plans are, as I mentioned, are increasingly being asked to provide care to disabled and elderly populations who have different, more complicated care needs and require different services and provider competencies.

And the Medicaid benefit package is generally more comprehensive than what is found under typical employer-

based coverage. Services such as transportation and case management are often Medicaid-covered benefits that are rarely included in a commercial product.

And lastly, State environments differ considerably in many ways, and the variations in managed care programs must be made to accommodate State-specific conditions.

And outcomes to State variation keeps getting brought up. Variation across States for Medicaid managed care programs are great. When the States design their programs, there are a lot of factors that they consider. First, should a managed care program be Statewide or only within certain counties? As I mentioned earlier, there are a number of communities, especially in rural areas, where managed care is just not feasible.

Second, what populations to include. For example, some States are starting to adopt managed care for the disabled while other States exempt or exclude these populations and are not going to move forward with that.

What services should States contract for is another consideration. Every State has a different plan benefit package. Some carve out behavioral health, others do not. The same with dental, prescription drugs, long-term

care, among just a few.

And then adding to the complexity, different services are in the plan benefit package for different populations. In New York, for instance, behavioral health is carved out for the SSI population but is a plan responsible for other Medicaid enrollees.

So this emphasizes the fact that it is hard to define a typical State program and that one size does not fit all when it comes to Medicaid managed care. Again, lots of variation.

The next steps. At the December meeting, we plan to have a deeper discussion on managed care issues focusing on what is known about access and payment issues in Medicaid and CHIP managed care. Over the next month, we are going to be undertaking considerable work to better understand how the managed care system works for Medicaid and CHIP enrollees with regard to obtaining care. We also want to get a stronger grasp on the issues surrounding payment issues. So I guess it's really trying to get under -- or seeing how we can get under the mystery of that black box that keeps getting brought up.

A couple weeks ago, MACPAC staff convened an

expert roundtable discussion with 16 experts in the world of Medicaid managed care. Marsha Gold from Mathematica moderated the panel, and I think she did a really terrific job of getting the panelists to share their insights and perspectives on the current and the likely role of managed care in Medicaid and CHIP as well as issues related to provider adequacy, payment rates, monitoring, oversight, and again, a lot of other issues.

So in December, Marsha will present the major themes and the concerns that were raised that day and she will also provide a synthesis of the literature on Medicaid and CHIP managed care focusing on access and payment. So I think her findings next month will really help guide us on a discussion on access and payment, and hopefully helping the Commission and MACPAC set priorities with regard to managed care. Thank you.

CHAIR ROWLAND: Questions? Andi?

COMMISSIONER COHEN: This might be a hard one, but do you know anything about -- I have heard this, but wondered if it's true or what we know about it -- that sort of the average -- there's a lot of turnover, of course, in Medicaid in many States and that the average stay in a

managed care plan, I knew from New York, was very short, you know, less than a year. Do we know how that compares to commercial and how that sort of affects how we think about how managed care is used in Medicaid, you know, that each person tends to be -- because people roll in and out of Medicaid a lot, and maybe that will change, and they roll in and out of their managed care plan a lot.

MS. SIMON: Now, I think it's very interesting, because --

COMMISSIONER COHEN: Is it true? Is it --

MS. SIMON: I mean, I honestly don't know in the commercial plans what the turnover rate, you know. I would think you're generally in your plan until you either take another job or your company decides to choose another plan or insurance. But it would be interesting to look at that. And I know a lot of States are trying to do continuous coverage, you know, regardless of eligibility, keeping the member in for a year.

COMMISSIONER CHAMBERS: Yes. I was just going to add, you'd have to segment the populations, too, because in our plan, we've been serving seniors and persons with disability for 15 years in mandatory enrollment. So that

part of the population is pretty stable, as they generally don't leave the plan.

MS. SIMON: Yes.

COMMISSIONER CHAMBERS: The only thing that changes is when they become dual eligibles, and then just the payment source changes. But in the TANF population, certainly there is turnover, and I think you see that in commercial plans, is there's a lot of turnover and changing of options.

I had a couple observations as to -- one thing is I'd encourage is whether the Commission wants to adopt ACAP's term, is plans that are Medicaid dominant as Medicaid focused, because being one of those Medicaid-dominant plans.

[Laughter.]

COMMISSIONER CHAMBERS: So I'd encourage us to use the Medicaid focused. And actually, ACAP's term is Medicaid and CHIP focused, because most of those plans are actually those plans.

Also is to encourage slicing the Medicaid-focused plans a little bit further, is not all of us are sponsored by provider organizations.

MS. SIMON: Right, and that's something we

definitely want to get into and try to understand the dynamics and how it's changed, because --

COMMISSIONER CHAMBERS: Yes. I mean, in California, there's a whole large percentage of managed care is provided by public plans that are community-focused that are created by the community. Actually, the only other place in the country that has a similar plan to what we have in Orange County is in Minnesota and actually was a response to Minnesota's 1115 waiver, was for rural counties is to create some kind of organized delivery system. And what happened was there was no commercial managed care present, and so these rural counties in Minnesota actually adopted the same thing that California did in 13 counties, which is a community-organized plan where a single entity actually organizes the integration and coordination of care for the community. So it certainly is a model that has -- it tends to be West Coast-based, but certainly is something, I think, that is worth looking at as we think, are there alternatives to traditional managed care in some locations, particularly underserved areas.

And another thing is the big discussion if anybody goes to any conferences anymore is ACOs and what is that

impact on Medicaid. In ACA, I guess there's an opportunity for children's demonstrations for Accountable Care Organizations, but if you talk to anybody in the managed care industry, the future is ACOs. So what is going to be the impact on Medicaid of that.

MS. SIMON: And I think we're going to have to look at that and within the ACA how managed care is going to interact with the ACOs, with the exchange, with medical homes or these demonstration projects.

CHAIR ROWLAND: Medical homes would become health homes.

MS. SIMON: Health homes, yes. Yes.

[Laughter.]

MS. SIMON: It's hard to change.

COMMISSIONER COHEN: Is it okay if I come back? Oh, I'm sorry. The primary care case management, enhanced primary care case management, who does those? I turned to Mark and asked him who is doing that in Pennsylvania, but sort of in general, like does it tend to be more provider organizations that are doing that or are they managed care organizations or are they different kinds of entities that do that primary care case management service, or --

MS. SIMON: I think there are different types of entities, and I think a lot of times the State will contract with an entity to provide, whether it's disease management or intensive care management, for those populations. So a lot of it is building on a PCCM program. And, you know, more accountability and more, you know --

COMMISSIONER RILEY: I think to Andi's earlier point and Richard's, the more we can think about the exchange in 2014, when you think about the exchange, and I think about it always vertically, and you think about families who dad might be in a subsidy plan program, mom and kids might be in Medicaid and CHIP. So you've got to think about the churn not just from the Medicaid people who go off every eight months, but those mixed families who are in the subsidized program, be it Medicaid or the subsidies, and people who go on and off coverage. It's a great opportunity, it seems to me, to sort of integrate and develop payment reform and different models. But we ought to think about that, because the first order question is, if I'm a health plan and I'm told in an exchange environment, you must take Medicaid and subsidy folks, my first question is going to be, and Medicaid pays me what? And think about

how do you track that and how do you make that work.

CHAIR ROWLAND: Well, one of the other big issues, of course, is the income fluctuation of people who will be in the exchange as well as people on Medicaid, and actually, there's less fluctuation among the lower income at the very, very bottom. But once you get over 50 percent of poverty, people are going to be drifting between plans in the exchange and between Medicaid and how that will all work. And the plans, I think, would like to have people locked in for longer than -- so continued eligibility becomes an issue.

COMMISSIONER RILEY: And you could lock them in because they have a subsidy.

COMMISSIONER CHECKETT: I have just a question, and perhaps it's directed more toward Lu, and maybe we'll hear this from Marsha when she's here in December. I would really like to have a better understanding about what is -- I get the idea there is a managed care black box, but what is it that people feel like they don't have access to? Is it that they don't have data, that they're suspicious of the reports from the State, that they can't tell if there is equal -- I don't know. I guess that's what I want to know.

Having done Medicaid managed care in a number of States, gosh, probably ten or 12, you know, actually, it and fee-for-service anymore are almost identical programs and there seems to be a wealth of information for the States. And so maybe it's just like not getting to CMS.

But I'd be interesting in finding out what's the black box concern, because for me, a really more important -- well, my perspective, more important use of our resources and our time is what does managed care look like going forward and how can it address the new populations and what is its new and evolving role. So, anyway, just asking you all for your thoughts on that.

CHAIR ROWLAND: You know, in the older days when it was all fee-for-service, it was very easy to count how many people you had, how many physician visits they had, and to just kind of count things, and so we got very used to in research comparing whether there was a disparity in access by the number of physician visits or the number of times somebody was hospitalized, et cetera.

And then I think when you hear this word "encounter data" all the time, it's that then suddenly when we were doing analysis, the managed care plans, you knew how

many people were in them. You knew what kinds of plans they were. But you had the utilization data kind of disappeared as your measure of access. And so I think that's one key piece.

Also, just when you look at things like physician payment, we don't -- we know how much from the surveys that are done by people like Steve Zuckerman at Urban. You can find out what the fee schedules are for different provider payments, but you're not quite sure under the rubric of managed care what physicians are being paid or what the provider networks are.

So I think it's just the whole set of questions that we haven't had answers to, and it's not necessarily a black box. There is data. There is information. But it's different information and it's not always available in the forms that people were historically used to working with or that allows you to compare to more broad survey data so that you can say, oh, well, people in managed care are getting more or less than something, but Lu?

EXECUTIVE DIRECTOR ZAWISTOWICH: And just to add to that, it's the whole question of what are we paying for, really just to embellish on Diane's point. What services

are being provided? Where do the premiums go and what are we paying for? And I think that's the overarching question.

CHAIR ROWLAND: Okay. Well, I think we have started today discussing with a very great set of presentations.

PUBLIC COMMENT

* CHAIR ROWLAND: This is now the time that if anyone from the public has a comment they would like to address to us, they can take the microphone and just please identify themselves. We didn't have a sign-up list or anything, but we welcome anyone who would like to offer some additional information to us.

[No response.]

CHAIR ROWLAND: And if no one would like to take the microphone, then it has been a productive but very long day, so I will adjourn the meeting for today. Thank you.

* [Whereupon, at 5:16 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, October 29, 2010.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

The Ballroom
The Fairfax at Embassy Row Hotel
2100 Massachusetts Ave., N.W.
Washington, D.C. 20008

Friday, October 29, 2010
9:15 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
HERMAN GRAY, MD, MBA
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
ROBIN SMITH
STEVEN WALDREN, MD, MS

P R O C E E D I N G S [9:15 a.m.]

CHAIR ROWLAND: Good morning. Good morning and welcome to day two of the October meeting of MACPAC.

We're going to begin our meeting today with a discussion of the dual eligibles. This is an issue that both MedPAC and MACPAC have been asked by the Congress to address, and we're going to begin first by asking Christie Peters, the principal analyst on the MACPAC staff, to do an overview of the dual-eligible population and some of the issues and challenges, and we're hoping that soon into her presentation Melanie Bella, who is in the Department of Health and Human Services with the task of organizing the Office of Duals and working on some of the administration efforts to coordinate care for the duals, will be joining us to continue our discussion.

So, Christie, welcome and start our discussion, please. Thank you.

STAFF BRIEFING: OVERVIEW OF DUAL ELIGIBLE ISSUES

* MS. PETERS: Good morning, everybody. It's nice to be here.

At the September Commission meeting, Mark Miller, the Executive Director of MedPAC, and his staff came and

talked to you about the work they have done regarding spending and utilization patterns among the dual eligibles and subgroups of dual eligibles, and you're going to hear later this morning from Melanie, who is going to talk to you about CMS initiatives regarding the dual eligibles. So what I'd like to do this morning is give you a brief overview of some of the issues involved with this population that is constantly navigating between Medicaid and Medicare for their services.

I'd like to highlight some of the characteristics of the dual eligibles, their Medicaid coverage, some of the issues that we face, all stakeholders face regarding these folks, and then talk about, as we move forward defining priorities and issues for the Commission to consider, some ideas the staff have for next steps.

Just real quickly, to review our charge, MACPAC is charged to review the interaction of Medicaid and Medicare policies and how those interactions affect access, payment, and the dual eligibles. MACPAC is to consult with MedPAC and the Federal Coordinated Health Care Office in CMS in work regarding the dual eligibles, and MACPAC is responsible for analysis and recommendations to change Medicaid policy

regarding Medicaid beneficiaries, including the dual eligibles.

So who are the dual eligibles? As we all know, there are over 9 million beneficiaries who qualify for both Medicaid and Medicare services. The dual eligibles are among the poorest, sickest, and highest-cost beneficiaries covered by either program.

Now, we know the health care status of the dual-eligible population is varied. There are dual eligibles that have limited impairments and medical needs and, therefore, limited interactions with the health care delivery system. But on the other end of the spectrum, there are dual eligibles with multiple chronic conditions, both physical and cognitive impairments, who are high-need and high-cost.

As a group, the dual eligibles have lower incomes, more health conditions, more functional impairments. They're more likely to have mental health conditions or be cognitively impaired.

Approximately two-thirds of the dual-eligible population are age 65 and older, and one-third is disabled. The younger disabled dual eligibles and the oldest dual

eligibles in need of nursing home care are the most expensive to care for.

This graph shows how the dual eligibles make up disproportionate shares of Medicaid and Medicare spending relative to their enrollment. On the left-hand side of the graph, you'll see that in 2005 dual eligibles represented 18 percent of total Medicaid enrollment, but accounted for 46 percent of total Medicaid expenditures. The right-hand side shows that for the Medicare program the dual eligibles represented 20 percent of total enrollment, but accounted for 28 percent of their total Medicare spending.

The dual-eligible population includes Medicare beneficiaries who spend down onto Medicaid, most commonly through nursing home care expenditures. The dual eligibles also include individuals who are disabled who qualify for SSDI and are in their 24-month waiting period for their Medicare eligibility to come through.

There are younger dual eligibles. These are Medicaid beneficiaries under the age of 65 with certain diagnoses which can qualify them for Medicare. There are also Medicaid beneficiaries who age onto Medicare, turning 65.

Medicaid coverage for the dual eligibles. Over 80 percent of the dual-eligible population qualifies for full Medicaid benefits. These folks are commonly referred to as the full duals. For these beneficiaries, Medicaid wraps around Medicare and covers services that have limited or no Medicare coverage. So Medicare is their primary payer for their acute care services, and then Medicaid wraps around, filling in some gaps, and providing long-term care services if it's needed.

Some of these services that Medicaid covers include inpatient psychiatric hospital care and nursing home care, home and community-based services, dental care, medical transportation services, vision and hearing. The extent of this wrap-around varies from state to state because the majority of these benefits that Medicaid is wrapping around are optional benefits.

In addition to these Medicaid services, Medicaid is also obligated to pay the Medicare Part A and Part B cost sharing for these beneficiaries. So these full duals get all of Medicare, all of Medicaid, and Medicaid pays for their cost sharing.

The other 20 percent of the dual-eligible

population just qualifies for the financial component of Medicaid paying for the cost sharing for Medicare. These folks are put in these programs that are called Medicare savings programs. You have under Tab G of your book a table that lays out all these different groups. These are these QMB, SLMB folks. You do not need to memorize that, but what's important to know is that there is 20 percent of that population that are supposed to be getting Medicare coverage for their -- Medicaid coverage for their Medicare cost sharing. These folks tend to have higher incomes. We're talking about 100 percent of the federal poverty level up to like 135 percent, okay? And the level of their financial benefit from Medicaid depends on their income, and that's all on that chart.

Some of the issues surrounding the dual-eligible population are highlighted on these next two slides. Cost of serving the dual eligibles is a concern at both the federal and state level. Growth in the cost of treating chronic disabling conditions is a major cost driver for both programs. Long-term services and supports is the biggest cost of duals for Medicaid.

Data is another issue. In order to get a complete

picture of the services and utilization expenditures of dual eligibles, we need to merge Medicaid and Medicare data. At the national level, all the Medicaid data issues that Penny and April highlighted yesterday obviously apply here with duals, and then it's compounded because you're now marrying this up with some Medicare data as well.

Going in the other direction, states are frustrated because they are trying to get Medicare data in a timely fashion, and there are some challenges to that, particularly with respect to hospital and Part D data, which is what they're most interested in.

A third issue involving the dual eligibles is that there are barriers to coordinating care across Medicare and Medicaid. These barriers are statutory, regulatory, administrative, and financial, and they can affect the decisionmaking that goes on along the continuum of care from acute care settings into long-term care settings, and this can ultimately affect patient outcomes and costs.

There are integrated models, namely, the Program for All Inclusive Care for the Elderly, the PACE model, and also Medicare Advantage Special Needs Plans contracting with states that are these fully integrated coordinated care

models. The MedPAC staff are currently examining these. And these are two approaches to overcome some of these challenges of coordinating care. However, enrollment in these programs is small, and there are challenges to replication.

One of the issues for replication on these coordinated care models is managed long-term care. These programs are small in number and enrollment, and there's limited state and provider experience in designing and operating such programs. They involve long planning and start-up periods, and there's resistance from stakeholders, namely, providers and beneficiary groups; and also there's concerns about ensuring and measuring quality of care in a long-term managed care setting.

Going back to the 20 percent of folks who only receive the financial assistance from Medicaid, there are some issues involving those folks as well. Issues regarding eligibility determination, outreach, and enrollment is a concern. There are also issues regarding Medicaid payment of Medicare premiums and cost sharing and the impact on beneficiary access. While Medicaid is obligated to pay this, many states pay their reimbursement for cost sharing

based on Medicaid rates, not Medicare rates, and there have been concerns about that limiting access.

So as we move forward, staff proposed to convene an expert panel to help identify issues for the Commission to consider. This panel will include representatives from the research community, beneficiary groups, and providers. State perspectives will be represented as well, and issues to be addressed will include data, payment, access, and quality. We will report back to the Commission the recommendations of this panel, and based on the panel discussion and direction from the Commission, the staff will develop an analytic work plan which will incorporate a research agenda that will include consultation and input from states.

Staff will continue to coordinate and consult with MedPAC and the Federal Coordinated Health Care Office in CMS and update the Commission on their respective work. The staff is seeking direction from Commissioners regarding MACPAC interests and priorities regarding the dual eligibles.

Thank you.

VICE CHAIR SUNDWALL: Christie, thanks for that

presentation. I certainly learned something. I didn't know a lot about duals, partial and full, what have you.

Your next steps seem very measured. Is there any expectation of Congress or staff on the Hill that they might have some policy direction this coming year? Or is this something that we can put on a mid- or lower priority from other charges we have?

MS. PETERS: At this point in time, I'm not aware of anything that they are considering any time in the immediate future. There has been a lot of activity in recent years, but I don't think there's any interest in doing anything specifically with this population at this point in time. But I will check and get back to you.

VICE CHAIR SUNDWALL: Thank you.

CHAIR ROWLAND: What's the timing on MedPAC's deliberation?

MS. PETERS: MedPAC just finished doing site visits to three states, and they are --

CHAIR ROWLAND: For the Commission, would you explain kind of where MedPAC has been, just as you're about to do?

MS. PETERS: Okay. Basically, what MedPAC has

done is they've reported findings on the dual-eligible spending and utilization, and basically their findings talk about the variability within the health status and spending of dual eligibles.

They're currently focusing on the coordinated, integrated care model programs, the PACE programs and the SNP programs. They've recently conducted site visits to New Mexico, Massachusetts, and North Carolina. They've also had conversations with other states -- Arizona, Minnesota, Virginia, Maryland, Vermont, and Oklahoma. They have a November meeting next week where they're going to present their findings from those site visits and conversations with those states.

CHAIR ROWLAND: Why don't you explain for some of the Commission members the PACE model versus them and what they are?

MS. PETERS: Okay. In Tab G of your book, there is a page that explains what the PACE model is. It's the Program of All-Inclusive Care for the Elderly. It is a fully integrated model where there is an interdisciplinary team of providers who are responsible for assessing and delivering, coordinating the care of medical needs and

additional services for the population. It's mostly the frail elderly that are in this program, and they receive capitated payments from Medicare and Medicaid to deliver these services, and they are full risk for the services they provide.

Then the Medicare Advantage Special Needs Plans, these are Medicare Advantage managed care plans that have received designation of being a Special Needs Plan by CMS. This allows them to restrict their enrollment to certain groups of populations. There are Medicare Advantage Special Needs Plans for the institutionalized, the chronic needs, and also for duals, for dual eligibles.

Some states -- and, again, in your materials you have a chart that shows the states that are moving forward with integrated care models and which ones are contracting with Special Needs Plans. Some states have collaborated with these plans, come up with contractual arrangements where they are providing in a managed care setting both Medicare acute and Medicaid long-term care services in an integrated model using these Special Needs Plans.

COMMISSIONER CHAMBERS: Could I just follow up with a question? Does MedPAC specifically have a time frame

of when they're going to report something, you know, as a recommendation in one of their annual reports?

MS. PETERS: I am not aware of any timeline. It is my understanding that they're going to present their findings from their site visits and phone calls they've been having with the states, and they are starting to head down the road of coming up with some recommendations. But I am not aware of their time frame.

EXECUTIVE DIRECTOR ZAWISTOWICH: Richard, right now they're just -- again, as Christie indicated, they're going over the results of their site visits, and they're beginning to consider possible policy directions, but there isn't a specific time frame. And I'm not sure if they will be including this in their March report or whether they're going to be including it in June. So we just need to coordinate with them further.

COMMISSIONER CHAMBERS: Yes, I would just encourage us -- I guess my skepticism after all the years at CMS is: Is a dual-eligible low-income Medicare beneficiary or is it a Medicaid beneficiary that also has Medicare benefits? And if MedPAC approaches it the same way the administrations over the years have approached it, it is

taken from a Medicare perspective, and Medicaid is such a big player -- even though there's the Special Needs Programs and PACE programs, they are one component, but they are not the answer by any means to this problem.

I just would encourage us to make sure we know what their time frames are. I would even suggest the possibility, since this is a unique issue that crosses over both Commissions, would there be something, if it moves on a fast track, to think about having an ad hoc of maybe Commission representatives from both committees that are very interested and concerned about the dual-eligible issue, as to suggest some closer collaboration rather than waiting until each committee sort of does its work and then tries to bring something together at the end. So I'd just suggest that as a possibility.

COMMISSIONER **MOORE:** You mentioned the small number of people in PACE and Medicare Advantage SNPs. That's like less than 5 percent of duals or something? It's a very small number.

MS. PETERS: Yes, it is. There's roughly 18,000 people who are enrolled in the PACE programs, and there are 120,000 people that are enrolled in --

COMMISSIONER MOORE: It's actually smaller than I thought.

MS. PETERS: Yes, so it's less than 2 percent.

COMMISSIONER RILEY: That's nationwide?

MS. PETERS: It's less than 2 percent of the dual eligibles are enrolled in fully integrated plans.

COMMISSIONER RILEY: And the PACE model is a particularly hard model in rural places, but I would just say, at the risk of being Pollyanna-ish, that this is an exciting time for dual eligibles. I was cleaning out my office, as one does when one faces a term limit, and found a paper that Paul Saucier and I wrote for the National Academy for State Health Policy, and I'd recommend Paul for your expert meeting, but it was written on dual eligibles and how to serve them in, I believe, 1993. So this issue has been bubbling. Nothing is new in terms of what the problems are. What's new is the federal -- ACA does have demonstration money, and the Federal Government with this new construct to get Medicare and Medicaid actually planning this thing together seems to me is extraordinarily helpful, and we ought to keep our eyes on the prize and help the CMS folks do the best job they can to bridge that great divide.

CHAIR ROWLAND: Thank you. This is a huge issue which mostly you can talk about forever, so it's an interesting point.

In terms of looking forward at some of the analytic work we would do, would we go out -- do you envision going out and doing site visits like MedPAC did?

MS. PETERS: Yes.

CHAIR ROWLAND: Trying to find out where there are models on the ground that are working?

MS. PETERS: Yes. I think it would be extremely valuable to go out and do some site visits to complement not only the work that MedPAC has done in that regard, to build upon that, but also to explore other issues that this Commission is interested in pursuing. But I think input from the states is extremely valuable for the Commission on this.

CHAIR ROWLAND: And I don't know, Andi, if it's still true, but a long time ago New York City had the ability at the city level to do integrated analysis of both Medicare spending and spending for the same population. And so there may be some opportunities to look at places -- if the federal data doesn't allow this kind of linkage, there

may be some opportunities at the state or local level where there has been more data coordination. I think Rhode Island at one point was also doing some coordinated data between the Medicare and Medicaid population.

COMMISSIONER COHEN: Right. I don't know that we've been doing it in recent years, so I will look into it and I will check in with Deborah Bachrach.

CHAIR ROWLAND: Who will be here later.

COMMISSIONER COHEN: Yes.

COMMISSIONER CHECKETT: Christie, I was just wondering, one of the issues the Commission has wrestled with is our desire not to replicate work that has been done already, and there has been a lot of work done on dual eligibles.

MS. PETERS: Yes.

COMMISSIONER CHECKETT: Do you have any sense of how you could summarize that and give us some ideas of what a different or unique approach would be for the Commission to pursue?

MS. PETERS: Yes, I can.

[Laughter.]

MS. PETERS: I'd like to think about it. I would

like to put something down in writing and then come back and tell you.

I think there has been a great deal of work done, I agree with you, in terms of the duals, and we certainly don't want to duplicate, replicate. We certainly want to augment, supplement what has been done and what's going on currently. Like I said, MedPAC has been quite active in recent years on these issues.

For instance, you know, we have known for a long time that Medicaid payment on the Medicare savings programs has really been a challenge, and I think it is ripe for folks to look at. There's concern about these programs sort of marrying up with the low-income subsidy program on the Part D side. That is a federal determination for the subsidy on Part D, but you have state determination going on for the cost sharing, so I think that is something that is worth evaluating and possibly bringing back to the Commission to look at.

Again, the whole notion of managed long-term care, integration and coordination on the Medicaid side alone is a challenge, not just across with Medicare but also just internally within the program. I think states are

interested in hearing about what are some components of those types of programs that could be replicated or could be used, like Lu was talking about, some model language or model ideas that would be easy to look at to possibly incorporate in their programs.

I'm sure there's lots more, but I will give it some thought and come back.

COMMISSIONER CHAMBERS: Could I add something? We heard at the last meeting from GAO about their strategy on what they're working on, and we have our friends from GAO here who have been working on this issue. I would encourage us to make sure, as we're collaborating with them, to again, you know, emphasize not reinventing the wheel, as so many people back since the 1980s have been dealing with this issue, is to make sure we don't miss anyone who's currently doing work, as there's independent analysis being done and duplicating efforts.

MS. PETERS: Right.

COMMISSIONER CHAMBERS: I'd encourage that very much.

CHAIR ROWLAND: I think that the other thing you might think about is, as we talked about a little yesterday,

looking within the duals population at the fact that not every dual is the same, and are there issues to break out between the institutionalized dual population where the long-term care services are coordinated, readmission rates to hospitals and other things are quite different than the experience of duals who are in the community, even with the full dual population, maybe looking at those with more severe mental issues and those with other kinds of disabilities, and especially I think the number of duals that are non-elderly, the disability population, may have some very different issues, and perhaps that's a way that we can provide some analysis. It's fresher and a little deeper than looking just across the overall dual population.

COMMISSIONER WALDREN: One question I would have is, when we talk about the 46 percent and the spend, we could manage that once they become a dual, and we put them in that population. Again, it's not a homogeneous population. There also could be the notion of how do you mitigate those before. So do we have an understanding of kind of the longitudinal view of those folks before they've come into that 18 percent? And are there access issues? So if they are on Medicaid before that, are there some access

issues that we can address to try to mitigate them before they get into that? And the same thing with Medicare if they're on that. Or do we have any idea?

MS. PETERS: Right, I think that's an excellent point. At our last Commission meeting, Sara Rosenbaum raised this notion of how are they becoming dual. Are they Medicare spending down? Are they disabled with a certain diagnosis that qualifies them for Medicare? And are they in that 24-month waiting period for their Medicare eligibility to get in? That has been a concern of folks as well that during that 24-month waiting period, while some of these people may be on Medicaid as they enter into that waiting period, there are a good number of folks who spend down onto Medicaid. And so the continuity of care gets kind of jumbled in there because they're on one program and then within 24 months their Medicare eligibility comes through, and their acute care goes from being delivered by Medicaid to being delivered by Medicare. And so that absolutely is an area, an issue to look at.

CHAIR ROWLAND: Welcome, Melanie. It is a pleasure to have you here. We've just begun our discussion of duals. Christie has given us an overview of the basics

of the dual population, some of the issues and challenges, and we've begun to talk about how to put together the Commission's work agenda around the dual issues, the coordination issues, with MedPAC. But obviously, another important player that we want to work with is the office that you are now heading, so we welcome you and hope you'll share with us some of the issues and challenges from your perspective, and then we can engage in a discussion of how our work and your work can be complementary. So thank you. And I apologize for having you walk straight in to the table.

CMS INITIATIVES ON THE DUAL ELIGIBLES

* MS. BELLA: Not a problem. I am sorry that I wasn't here sooner. I always like to hear what Christie has to say.

Well, thank you. Good morning. My name is Melanie Bella. I really appreciate the opportunity to be here. I think it's tremendously exciting to think of the opportunities of where we might be able to collaborate, and so I appreciate Lu reaching out to us early on, and Diane, thank you for the introduction.

So I thought it might be helpful just to give you

a context of what, from a CMS perspective, what the Administrator, Don Berwick, his priorities, and those priorities then really help us all establish our own priorities, and you may have heard these before. But essentially, we have four strategic aims. First is dealing with basically excellence in operations. The second has to do with care for patients. The third is all about integration, and this is where the Triple Aim of quality, cost, and improving community health comes in. And then, again, as a stand-alone to impress the emphasis on the health of populations and communities.

Every single one of these touches duals. If you think about operationally, all the misalignments that are occurring, the opportunities for improving those things. Obviously, better care for patients and integration of care is what we're going to spend the lion's share of time talking about. But when we think about health of populations and communities, there are some tremendous opportunities from a preventive aspect if you think of the pre-duals, as well, that we really haven't been tapping into yet today.

So I don't really have to tell you this, and I'm

sure Christie emphasized this, but I do find it helpful to remind people, both internally and externally, about who this population is and what it is we're doing for them, which essentially is we're spending an awful lot of money and we're not getting very good care. And so that, in a nutshell, is a tremendous opportunity in terms of access, quality, and cost for this population that we call duals, who are entitled to Medicare and Medicaid benefits.

I have the privilege of getting the Federal Coordinated Health Care Office up and running. By shorthand, they call me Section 2602, as everybody goes by their particular section or sections. So I'm sure many of you are familiar with 2602. At the highest level, we're really there to improve quality, reduce cost, and improve the beneficiary experience. If you've read the statute, you see throughout is woven this notion of improving the beneficiary experience. Whether it's talking about access to services or understanding the system or improving the ability to navigate the system, it really is written with the beneficiary in mind, and that really is how we're structuring the office, all from the perspective of how is this going to impact the people who are supposed to be

receiving both of these sets of services today. And then that is the lens we use to drive policy, program, reimbursement, measurement, evaluation, all those things that we'd like to talk to you about today.

So a few of the things that the office is responsible for doing. One is to ensure full access. Two is to improve the coordination between Federal Government and States. It's time to change that relationship, and I think we have -- it's a great opportunity to do so. Third is to look at innovative models for both care coordination and integration. And the fourth, and this one is -- the importance of this cannot be understated -- it is to eliminate -- and I don't use that word lightly, we really are seeking to eliminate financial misalignments. It is the financial misalignment and the incentives for cost shifting that is responsible for the lion's share of things that we believe are contributing to poor quality and inefficient use of resources and not an overall positive beneficiary experience. So since you all are looking at payment and access, we are excited to have your wisdom in these areas especially.

Again, just to emphasize, the focus really is on

the beneficiary and on person-centered care delivery. Those words mean different things to different people, but essentially, we know there is room to improve in how dual beneficiaries access the program, and then improvement in their health functional status and well being.

We know there are a handful of critical issues -- more than a handful, actually, but some that are worth noting. The first one, again, goes to the incentives issue, aligning the incentives between Medicaid and Medicare to actually reward value and an improvement in outcomes, which is not the way the programs have been designed today.

And let me just say, I don't mean to sound critical of one side or the other. The programs function exactly the way we designed them to function, and that's part of what we're seeking to change. They weren't designed to interact well for a person that gets both services. So Christie has probably been through all of this.

I want to emphasize, as well, the second bullet. We have a real obligation to enhance the capacity from an analytic perspective of understanding what we do and don't know about this population and how we're going to improve what we do and don't know. So we believe that we need to

work with States and work internally within CMS to increase the analytic capacity and the ability to have appropriate and comprehensive measurement sets and to really do evaluations of care models on all of the things that we addressed.

Additional issues that are critical is looking at models of care and delivery system reform. So we will be entertaining innovation proposals to work on these things, and I'll talk a little bit more about that. And I want to emphasize, this could be working on enhancements to existing models as well as developing new models. So there are some really good things that have worked, and the notion is not to just discard those, but if there are ways that we could enhance those, whether it's the traditional Medi-Medi demos or it's PACE or it's some of the work that's happening today with some of the SNPs that are fully integrated. There's no need to think that we can't build on those while we at the same time try to create new models on both the delivery system and the payment side.

We have what I'll call some high opportunity areas, and these will come as no surprise to you. These also align pretty well with some of the broader initiatives

going on within CMS, more so on the Medicare side than the Medicaid side, but certainly opportunities to evolve to Medicaid, as well. This has to do with care transitions, avoidable admissions, preventable readmits, looking at health homes, and this is a very big Medicaid initiative, medication management, behavioral health, and I want to emphasize the importance that this office is going to put on behavioral health.

This is an area that we are going to tackle head on and believe that it is one of the fundamental drivers of utilization, poor quality, and poor cost that we're seeing, particularly in the under-65 population. The profile of someone with or without mental illness is dramatically different in a similar way to the presence or absence of dementia on the over-65 population. But this population and the effect of behavioral health and how States and plans are providing behavioral health services has been under study and we really need to address that head on.

I will make one note there. Some of you may be familiar with the Chronic Condition Warehouse at CMS that is used to help give a diagnostic picture of beneficiaries, and one of the challenges on the Medicaid side has been that the

Chronic Condition Warehouse has been designed using Medicare conditions and it does not have diagnoses for serious mental illness, and we actually have changed that and so we expect to have that added by the end of the year or first of January, so we're excited about that. Again, it just helps expand our understanding of the population that we're talking about.

And then health literacy is an important area that we would like to focus on, as well, especially as it's tied to our obligation to improve the beneficiary experience and understanding of how to navigate the system.

So I'm going to talk next about some of our demonstrations, but I thought that it might be helpful first to step back and tell you a little bit about how the office is going to be structured to give you context for this. Generally, we feel that we have two big areas of responsibility. One is to -- one we will call program alignment, and that is addressing everything where the two programs butt up against each other today. So this is administrative, regulatory, statutory, in all areas, enrollment and eligibility, marketing, grievances and appeals, performance and quality measurement, rate setting,

you name it. The list is long. But that is a large part of our charge. If you notice in the statute, we are charged with addressing and eliminating regulatory and statutory conflicts as well as the cost shifting, and the cost shifting really is driven by these places where the two programs butt up, which will be tackled by this bucket.

And our challenge in this one is just to know where to start, because there are so many things that we could do. And so what we're in the process of doing is collecting as much input as is available. We certainly have a lot of input internally about places where we think there needs to be better alignment. But we're on a major external stakeholder listening period where we're gathering that feedback, as well.

Then our next step is really to have a way of assessing the impacts of changing those things. So how many beneficiaries are we going to help if we fix this one instead of this one? And it's not to say that either are unimportant, but it is to say that with limited resources, we have to have a strategic and transparent way of deciding how we're going to assess where to start.

So all of that, then we'll overlay that with the

lens of understanding what sort of action would be required. Is it sub-regulatory? Is it regulatory? Is it statutory? And that will all drive a process to come up with a prioritization list, and we'll think about it kind of as a 90-day hit list and then a six-month, a 12-month, and an 18- and 24-month plan. And we will be very transparent about that and very concrete. Those of you that know me know that I'm very concrete and we will have this list and we will do our best to get feedback and start to check things off this list.

And everything will make it on the list. It's just we also have to level set expectations that it can't all be done immediately, despite the fact that we would all like to.

This is probably where I should tell you that we're a small but mighty team.

[Laughter.]

MS. BELLA: We will have 14 people, which is a doubling of what it was when I took the job about four weeks ago, so we've managed to get seven more positions, which is huge over there in this environment right now. And we do have a program budget for 2011, so those are two good

things. But it's going to take us a little bit of time, but it doesn't mean that everything isn't going to take the list.

And I should say, also, this is where a lot of the work internally is occurring. So we have set up formal and informal structures, and I can talk a little bit about that near the end.

So the second bucket of work is all about demonstrations, and so we will have a group that is responsible for demonstrations, models, and analytics. We have the luxury of partnering with the Center for Medicare and Medicaid Innovation, and I don't know if any of my CMS colleagues who came before me did say that it is going to be CMMI, so it is going to have a double "M" in the name. Medicaid is not forgotten. And we are going to be partnering with CMMI for two things: One, the authority, the demonstration authority, and two, the funding. So our funding to do demonstrations will come through the Innovation Center, which we are very fortunate for that.

We expect to have -- obviously, the demonstrations as noted are testing two main things. One is delivery system and two is payment reform. Clearly, with the lion's

share of duals still in fee-for-service systems, there's a huge need to try new delivery system models, and given all the problems that we know with the financial misalignment and the cost incentives, there's an equally large need to test new payment models.

We expect to have three categories, if you will. One is States. Two is providers, and I say providers loosely. That could be provider organizations, health plans, PACE entities, Accountable Care Organizations, health homes, so take it very generically, and beneficiaries. On the beneficiary side, we believe there are some exciting uses of technology that have been applied in other sectors that might be -- we might want to try to think about applying to a low-income complex population with some cognitive and language issues that we haven't tried in the past.

There are a number of considerations that will go into the decision making process around demonstrations. Some that I have noted there include blended funding and shared savings, and why I think that's important to mention is just there are many existing vehicles today to do waivers and demonstrations and there's no need for us to come in and

usurp what's working well if a State has an 1115 waiver, if a State has a 1915 waiver, for example. The reason to use the Center for Medicare and Medicaid Innovation is if there is an interest in doing something different with both funding streams because it is that piece that isn't available on the Medicaid side of the 1115 and the 1915 waivers.

In addition, Cindy Mann and I have had some good conversations about perhaps we actually could get a new way of looking at 1115s and see if there's a way to count Medicare savings toward the budget neutrality even if we're not physically sharing Trust Fund dollars. So she and I might be naive, but we're going to try that conversation again. In the meantime, we are going to pursue the Innovation Center authority.

So the next consideration just goes back to the Triple Aim. Those of you that have heard Don talk, it is all about the Triple Aim. It's all about quality, cost, and the care of communities and populations.

The potential for rapid learning -- the Center for Medicare and Medicaid Innovation is designed to be different than how CMS has done demonstrations in the past, and it is

this notion of rapid cycle learning. I think of it more as a venture capital fund. We have a little bit of seed money. Going out and developing prototypes, incubating them, and quickly making go or no go decisions about can we scale this or not. And it has to be a little more rapid, both because the need is great, because there are no budget neutrality provisions on this one, which means you can't just have it open-ended with a long period of time without knowing if it's directionally heading the right way or not. And just a whole host of other reasons about thinking differently about how we evaluate these models.

Now, the challenge for the duals demos will be these aren't -- the outcomes that matter aren't ones that are necessarily going to change rapidly, and so we have to figure out a way to bridge that tension of how are we going to learn that we're headed in the right direction, and we want to continue to grow these programs even though we know it's going to take a while to see some dents in some of the measures that we want to move. So we have to be careful about our expectations, too.

And then another consideration is future diffusion and scalability. As you all have talked in other forums,

and I'm sure in this one, scale is an issue and we just have not seen many of these models be able to get to scale for a whole number of reasons. So part of our job is just to change that.

So a quick update on where we are. We have the office established and hiring is underway. We have about four spots left to hire. I can mention a couple of names that will be familiar to you. So I have a deputy that I stole from the Medicaid side of the house, Cheryl Powell, who some of you know, and the person who is heading the program alignment group, the director of that office is Sharon Donovan. Many of you worked with her on Part D issues. So she momentarily thought she was going to go to OCIIO and we persuaded her to stay and help us get the duals office up and running. So we're excited about that.

And we are just in -- we have had very good success with collaborating with Cindy Mann and Jon Blum to say, okay, who on your teams can be sort of informal members of our team and vice-versa, and so far, so good. Obviously, it's nice to have so many former Medicaid directors in the building. And then we're establishing those relationships on the Medicare side, as well.

We have formal coordinating committees internally. That committee brings together all of the acronyms within CMS that touch duals. And then we also have an HHS formal committee because we want to bring in SAMHSA and AHRQ and AOA and the Office of Disabilities and ASPE and every other entity that is doing something that touches this population.

Part of what our office has started doing is just -- it will sound little, but believe it or not, it's not -- making an inventory of all the programs out there, all the analytic files, all the evaluations underway, because that either hasn't existed or we haven't found it yet if it does exist. And so our job is going to be to be a clearinghouse internally and externally, a go-to spot for these sorts of things.

We obviously have begun interaction with MedPAC and MACPAC. Lu and I had a chance to talk before, and being able to come and hear your input is -- this is very timely for us. We have talked with Mark and MedPAC, and so figuring out how the three entities, recognizing the two of you are independent commissions, but how can we make sure that we're shaping the things we're doing to support the goals of your commissions, as well.

We are doing constant internal and external stakeholder outreach, trying to be very open and hearing from all the folks that want to talk to us. I'll be honest with you. It's more helpful when people bring concrete ideas, especially if they bring data and outcomes, and we don't get that very often. And soon, we will have to stop talking and start acting. But we do want to figure out the right balance of continuing to be an open door, of getting information yet still not getting caught up in actually starting to make some movement.

We are working on developing State profiles. This would be information that is State-specific about the duals population. The challenge here is that there are so many variations in Medicaid that to be able to make all the necessary adjustments to have something be comparable is a challenge. The intent is not to make this comparable information, but, you know, any time you put out more than one piece of information on a State, the States start comparing themselves, so we'll have to figure out how to balance that.

And we do have an external contractor who is working with the office to do things, some analytic work.

We are doing focus groups of dual eligibles. We are doing site visits to States. We are also doing some actuarial assessment and some modeling. The contractor that has been selected in Thomson Reuters, and then Thomson is working with some other subcontractors, the Hilltop Institute, Mercer, and some others, to help fulfill what Mercer is doing.

I took the liberty of listing a few things that perhaps might be areas where we could collaborate. I am hopeful that we can get some discussion. One would be a common analytic framework or agenda. As I mentioned, this office is really taking responsibility within the agency for having a much better grasp of what we do and don't know about this population, for being the shepherds of the linked data sets, for getting encounter claim data into the fee-for-service data, for making those data available to States and then eventually to other providers. I mean, researchers seem to get it easiest right now. The first priority is to get those data in the hands of States.

I have not yet encountered the Office of General Counsel at CMS, so I'm afraid I might not be able to make that happen quite as quickly as we'd like, but it's high on

the list.

So the question would just be, rather than all of us -- we know MedPAC has invested, has done some tremendous work with the help of Mathematica in looking analytically at this and then with some work that will come out at their November meeting. We know we're poised to invest money in data and analytics, and we assume that analysis and data is going to be a large part of this Commission. So short of commingling dollars, which I assume is difficult, how can we at least, or can we at least agree on a set of research questions or common agenda questions and be able to say, oh, you've already figured that out and you're on the hook for this one -- some way of at least starting from a common understanding and common set of assumptions, which I don't think exists today. And then that will obviously drive analysis of care patterns.

One of the things we want to do early on is really get a better sense of the subpopulations here, so all the different ways you can slice and dice, whether it's folks whose needs are acute care driven versus long-term care driven, whether it's institutionalized or home and community-based, presence of mental illness, all of the

factors and the different ways that we could provide better care models for this population.

Collaboration opportunity could exist around development of tools. We are charged with doing technical assistance to States and others, and so we'll be developing a tool kit and a process for doing that. The question would be, is there a way, again, to make sure that we're moving in the same direction on that.

We obviously are spending a considerable amount of time on the whole issue of administrative, regulatory, and statutory barriers. To the extent that MACPAC has input on some of those things that it feels need to be addressed sooner rather than later, that would be helpful. And then if there's a way to align with what MedPAC is focusing on, as well.

I would say -- I put a shameless plug in to Lu, so I'll do it with the public forum, which is one of our charges in the statute is to -- well, we have three things that we must report on annually. One is to do a drug study of all full benefit duals. The second is to do an annual reporting of expenditures, outcomes, and access. And the third is to give -- the Secretary makes recommendations to

Congress as part of the budget process, and so we will feed into that process.

It's the second one and that word "access" in particular that is a real challenge to us. We are working with Cindy and others at CMCS on how to best think about access. We know she's thinking about it in light of the whole issue of ensuring payment rates are adequate to have access. But the notion of being able to annually report on access means we have to define it and have a way to measure it and monitor it and actually see if we're improving it, and I'll be honest with you. We're not clear on exactly the best path forward on that. And so if there's input that this group has to make that meaningful and to be able to tie it back to what actions we would then take to try to improve it, we would be very interested in engaging in that line of discussion.

So I think, with that, I will stop and see if there are questions.

CHAIR ROWLAND: Thank you. Questions? Richard.

COMMISSIONER CHAMBERS: Thanks, Melanie. It’s really good what you’ve done in a short time and all the hope that those of us who have wrestled with this problem

for years and hope that finally there's going to be some path forward. So we really are enthusiastic about your work, and this Commission certainly looks forward to working with you.

One thing is, when you talk about the misalignment of incentives, particularly financial, I'd encourage both CMS, but also this Commission, as to how we can engage the major provider organizations, particularly AMA and AHA, at the local level when you see delivery of services to dual eligibles is these misaligned incentives.

For dual eligibles, for instance, we find, with a special needs plan is, the number one driver for decision for beneficiaries voluntarily enrolled in a special needs plan is driven by their doctor. Oftentimes, that's driven by financial considerations at the provider level.

I think where potentially you could bring together national organizations to support the efforts of serving the dual eligibles it would be very helpful, I think. When that trickles down to the local level it would certainly be helpful.

I think with this Commission, as we have focused on managed care and Medicaid is, we see the intersection of

the dual eligible coordinated delivery systems. It's something that we're going to have to grapple with, and I know it's a priority of yours of how the delivery of services happens. So we look how we bring those together because, as I like to talk about, is instead of managed care is coordinated integrated systems of care across the full range of Medicare and Medicaid benefits.

It's good to hear that you're focused on behavioral health as, again for those of us at the local level, the fragmentation on the Medicaid side is really telling as there's more and more focus at the state level about those issues. The dual eligibles is the key issue and so I'm glad to know that's a big focus of what you're going to be doing.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I'm beside myself with excitement. I really am. I really am. This is a great opportunity. But one of the things that I'm intrigued about is the payment reform approach, and the piece of the ACA that has the shared savings, ACO and Medicare that I think is next year, it strikes me that there's real opportunities if we can find a way to piggyback, because what's going on,

of course, in the states is the private sector is doing ACO models, different state activity is going on. What worries me is it will be a little chaotic in the field and chaotic to providers and why not follow Medicare's lead and allow Medicaid programs to piggyback with it?

But how you'd actually make that possible is one provider or one provider organization and state potentially is beyond me. So I think there may be places there that we could find some harmonic convergence. Congratulations for taking this job and thanks for taking this job.

MS. BELLA: Well, you're welcome. I should thank all of you that helped get it into the legislation. But I would say we are thinking hard about how to take the ACO approach and make it adaptable for looking beyond the acute care benefit and spanning all of those things. Some of the -- and the Innovation Center is working on ACO testing as well. So that's another link that we have.

Some of the challenges in the Medicare-legislated ACO demo is just there's some rigidity in the first couple years about what they're looking at in a way. But there are lessons to learn and we especially have to look at it, quite honestly, because we're going to have states that want to do

the advanced primary care medical home demo who also want to do the ACO demo who also want to do a duals demo.

And so, especially when the shared savings is involved, if we can't get our act together to allow them to participate in all those things, it's going to be a real problem. So if anybody wants to think about how to create an ACO for duals -- and that's part of, honestly, what we'll be testing with the provider-based demonstrations and some of the state demonstrations as well.

COMMISSIONER COHEN: I didn't want to start with this because I don't think it's the most compelling issue, but something that I would like to be on like maybe the midterm agenda for MACPAC to think about, the Medicare savings programs. They're a messy set of small programs with low take-up, or some of them have higher take-up, low take-up, very fragmented.

Their purpose, I think, is a little bit unclear and I don't think we know anything about how much they affect access, how much they really are just almost like an income support, just sort of like what their function is. Do they provide health value? I'm not suggesting that they don't, but I just think we don't know very much about it and

that there is a -- it's very low hanging fruit to try to, I think, to think about rationalizing these little confusing programs.

So I would like to put that on kind of our midterm agenda. It's certainly not the most compelling issue around duals, but it's something that would be easy to make an improvement in that area.

CHAIR ROWLAND: And, Andy, would you also consider having a look at how that relates to the low-income subsidy part of Part D?

MS. BELLA: I'll just say that is the number one issue that comes up on that list of things under the program alignment. And so, we are looking into MSP and particularly how to encourage states to exercise some of the flexibilities around the low-income subsidy provisions that would ease some of the things around MSP.

We have committed to the advocacy organizations that we would at least get out some best practices around that area and begin to work on how we could make other improvements. So we share your interest in trying to do something in that area.

CHAIR ROWLAND: Melanie, some of the concern in

the past about waivers and use of waivers has been kind of negotiated between states and the federal government without a lot of input and public view. Is there going to be a more public process as part of considering some of these innovations and demonstrations? Obviously you just mentioned advocacy groups who I know have had some concerns about how waivers are developed and enacted.

MS. BELLA: We really believe that part of our obligation is to come out strong with a set of consumer -- safeguards or protections sounds like it's a negative thing, but showing clearly that the goal is to have programs designed from the beneficiary standpoint.

Having said that, that means that we expect to see, in any given area where we would do demonstrations, that there has been stakeholder involvement along the way and an assurance that the consumer beneficiary voice has been represented.

Now, our biggest challenge, to be quite honest with you, is just having some uniformity of voice, because we don't. There isn't one and getting these -- so I'm encouraging these groups to work together so that when -- I mean, I must have 20 different lists of all the core things

that should be in these programs. We can reconcile them, but it's going to be helpful to get the broader advocacy community to begin to reconcile, particularly the divide in the over and under 65 communities.

So yes, the intent would be, on the demonstrations, to ensure that stakeholder engagement is occurring to have a very high bar for all those demonstrations and a key component being stakeholder involvement.

CHAIR ROWLAND: Robin.

COMMISSIONER SMITH: Hi, I very much appreciate your enthusiasm. Can you tell us a little bit more about how you envision education of the beneficiaries in the community, family members, on how do you see that going forward within the community? I think it's key to have them educated not only about how to navigate the system, but even to some extent why decisions are made. You get a lot of anger when people are turned down for services and if they understand the reasoning behind it, sometimes it can help. So how do you envision that education?

MS. BELLA: Well, I would be lying if I said we had it all figured out, but we're trying. We're starting

with focus groups of beneficiaries, and that's the first time that we've really been out in the field to talk to beneficiaries. We're also -- AARP is doing a series of focus groups of beneficiaries. They're going to share that information with us.

So that's going to be a starting point. I think we're trying to learn about what worked and didn't work well with Part D, because there's a wealth of information around that that we could build on.

And then beyond that, we're doing a lot of listing right now to try to understand how to better engage with community-based organizations and family care giver organizations, and then hopefully we'll have a better sense of how we might actually operationalize some of those things to make a difference and some way of measuring ourselves each year to see if we're getting better. If you have some ideas, we're open.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: Thank you for your presentation. I just wondered if you like your job? You're just about as enthusiastic as anyone I've ever seen. Glad you're there.

Two comments. First of all, I'm a practical kind of person and I'm hearing that this dual problem has been a conundrum for decades and it continues to frustrate payers and probably the providers even more. But after all this effort with demonstrations and waivers, aren't there -- and you referred to this -- aren't there some best practices you could call out now and share with us and with the public about what has worked well?

I don't know how long we can keep studying or evaluating. It seems to me like there must have been lessons learned that could be applied now. Is that on your priority list, to get some of -- review what waivers have been done, what demonstrations, what pilots, and then make it clear which ones seem to be working?

COMMISSIONER CHECKETT: No, I'm sorry.

MS. BELLA: You have a good historical knowledge of all this, too. I think if you take and OMB standard, OMB would say, we don't know anything because there's not hard -- there's not a lot of hard evidence on costs or quality outcomes. We have harder evidence on beneficiary satisfaction and areas such as that.

Now, having said that, there are really two

emerging programs we can draw from. One would be the existing Medi-Medi demonstration program. So Wisconsin, Massachusetts, and Minnesota. Those programs, depending on who you ask, arguably were more integrated a few years ago than they are today because they morphed into special needs plan status.

So some of the best practices that had been identified to integrate some of the policies and procedures changed a little bit because they didn't fit in the Medicare Advantage special needs plan world.

So having said that, we've learned a lot from those demonstrations. It's difficult to replicate those in other states because the context of the authority has changed. It doesn't mean they're not replicable, but it's more of kind of process practices than it is, boy, we know we hit the nail on the head with these care models, for example.

Then we have PACE. We certainly -- everybody who talks about PACE loves PACE. Internally, we don't have much on the evaluation side, I think, as you might like to have on PACE. And PACE remains small. It's designed to be for a very frail population. There are less than 20,000 people in

PACE still in 30 states.

So what we can take from PACE is the requirements of the multi-disciplinary care team, the understanding of the patient protection so we can take some of the pieces that we'd want to see in these models that we know matter for the complex populations.

And then we have special needs plans and that's what I put sort of in the kind of halfway category right now in terms of understanding because they're still new enough not to have a lot -- they haven't had large enough numbers of beneficiaries that are dual yet to really begin to see a lot of movement. Richard, you might comment on this.

I think we have data there that we have yet to mine. So, for example, all the special needs plans have to provide models of care now. We haven't linked models of care to the measures that they provide us. And so, you would like to think that you'd be able to see some patterns in terms of, well, these elements are here and these plans are showing greater improvement.

There are conversations to begin to make that happen, so I think the short answer to you is, there are best practices that we can pull out. We don't have as much,

I think, as everybody would like in terms of really demonstrable changes in health status and cost. But it doesn't mean that I would say, by any means, that these programs have been failures. Quite the opposite. We just need to do a better job of assessing different points, both qualitatively and quantitatively.

VICE CHAIR SUNDWALL: And I have more offer and then we need to hear from Donna. I would like to offer, and maybe I should have consulted with Diane before my fellow Commissioners, but you cited that you're going to prioritize your regulatory and statutory barriers. If we knew those, if they were clear, and there's consensus among us, we can help that happen. I think this report to Congress will be read and listened to. That's our hope.

And so, I'd rather be more proactive than just study this for another year. If there are clear things that you think would make it more possible to move things forward, let us know and we'll see if we can't weave them into our report.

MS. BELLA: Thank you.

COMMISSIONER CHECKETT: Thank you, Melanie. Always great to see you and hear your thoughts. I want to

share two points that the Commission has discussed, I think, in our recent meetings as well as yesterday and this morning, and one is really the conundrum of what is access, how do you define it, what does it mean. We have access to enrollment, we have access to eligibility, we have access to benefits, we have access to providers.

So it sounds like something that the Commission, that we should certainly continue to talk about as well, but you mentioned at the end of your comments that you'd like to know if we'd figured it out yet and the answer is, we have absolutely no idea.

But I personally think that it's one of the biggest things that we need to work on because there's so much talk about that issue and we've got to think there really has not been anything more than a lot of -- for the most part -- somewhat knee jerk summations of what access means or not. So certainly a priority for us.

We've also had a lot of discussion about not wanting to duplicate a lot of the great work that's been done already, and particularly for me it's been a lot of the work that you and others at CHCS have done on duals. I think to echo David's comments, I'd much rather move forward

on it than restudy it. So just some observations from where I see where we are so far.

A specific question to you would be, I know in all the research that's been done already, I think there's a tremendous importance to break out into buckets the different types of duals in terms of their costs. It's been an eye-opener for everyone to say, wow, look at the duals and how expensive they are. Then the next one was, and look, it's a handful of them that are costing us that much money. Then I think the break into behavioral health, in particular, is the key area.

One question I would like to know, and I just throw it out there because I don't know that it could be answered today, but when we look at the very most expensive dual eligible, my question for us to look at, to the Commission, to you, perhaps together, is, why are they costing that much money, and is it really something that we can affect? Or what's happened so often with the dual eligibles, Richard and I were talking about this in our special needs plans, they're rotating through and when they're rotating off it's because they've passed away.

And so, it's just a question to put out there, is

as we figure out where we want to focus resources, as much as we want to jump to the people that cost the most, let's make sure that there are people who we can really do something about. The fact is, there are also people that are costing a lot because they're at the end of their life and that's not particularly anything we can do about that. So anyway, a long series of observations. Thank you.

CHAIR ROWLAND: But then some of them cost a lot because they get readmitted over and over to the hospital, and is that a population that can be addressed?

COMMISSIONER CHECKETT: Right. And that's what I wanted us to be really clear on.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Melanie, just an observation. Once I heard a geriatrician say that they questioned the benefit to the elderly, any elderly person who was on more than five prescription drugs, and I was glad to hear you say, at the end of your presentation, that you're going to be looking at prescription drug use. I'm in a state where I know that the state's Medicaid program has much higher than average prescription drug use among the elderly. So I could see benefits for that study for the Medicaid population as

well.

MS. BELLA: I would just add one thought to what Diana and Donna just said. We do need to look. We need to bucket. We need to understand end of life. We need to do those things. This is where the whole notion of the pre-duals comes in, too. If we were smarter about a little front-end thing, we would keep a lot of people from spending down. We would fight some of the Medicare/Medicaid nursing home stay issues around. So I think we have a huge opportunity there, too.

A little dose of prevention up here could have a really positive downstream benefit for both Medicaid and Medicare. That's the type of policy change and states would need to fund things differently, but I think we could quickly show them a return on investment in those areas, and it would be good for the beneficiary, too.

So we would like to look at that piece as well to kind of counter the belief that we're going to go after all the high costs, some of whom we may not be able to impact.

CHAIR ROWLAND: And as part of that, would you want to take a look at people in the waiting period for Medicare benefits, as many of them will potentially become

your dual population?

MS. BELLA: Yes, we would.

COMMISSIONER MOORE: Melanie, in the last meeting and then this meeting, we've talked a lot about the great variability in Medicaid programs and resources that state staffs have, and you know that as well or better than anybody in this room.

How are you looking at that issue, the desire on the part of many Medicaid directors, many more now than a few years ago, for more federal help and more standardization and more assistance in putting together programs on the part of many states? Other states don't have the resources to do these kinds of things. How are you looking at that variability issue as you put your work plan together?

MS. BELLA: Well, part of it has been an incentive issue, states not feeling they have -- that it's not worth devoting resources to this because of some of the financial issues. So the first thing that we're trying to send is, we're going to try to test new payment mechanisms through the demonstrations which we hope will be helpful.

We plan to use some of our resources to provide TA

to states, either directly or indirectly. Oftentimes, what they need the most is travel dollars, access to best practices in other states and to their peers, and they need TA and they need to not have to go contract for that themselves.

And so, if we can assign pools of dedicate resources, for example, we'd like to standardize the approach that we use with states to help them plan the demonstrations and have access to pooled resources, because they're all going to tackle some of the same issues. Yes, they're going to need to tweak it, but there's no reason to think about modeling some of these things multiple times.

And another issue is if internally can we do more with the data and linking the data and paying for that behind the scenes, that they might not -- and giving it to them, those are the types of things that we're going to try to do, if that is the type of thing you mean.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: I'm the token actuary in the crowd. May I call you 2602?

[Laughter.]

COMMISSIONER HOYT: I really like that. Reminded

me of Les Mis and Jean Valjean. So I'm beyond pollyannaish. I went to Berkeley. I think it may be in my thinking back to some of those days.

You mentioned behavioral health. I'm not trying to be overly cute here. CMS does strike us, it's like somebody with multiple personalities sometimes. Everybody has seen this. The Medicaid side of the house -- so I'll kind of exaggerate a little -- almost warmly embraces managed care and is enthusiastically invested in trying different approaches beyond just whole risk contracting and HMOs or MCO models, lots of different things.

Whereas, Medicare feels like, to those of us, at least speaking for myself, has been more on the outside. We're not convinced at all. We're not much in favor. We sort of tolerate it, but frankly, I don't like it. Why doesn't somebody decide, do we believe in this or not. So this is beyond the pollyannaish part.

Why wouldn't you just decide who's better at doing this and forget alignment? Put all the money in the Medicaid side, or we can see it, we just give up, you know, Medicare do it, states, you're out of it, and the feds take it. Is that just silly talk? Would that even be considered

for a moment? It's like you're trying to align two different parties that hate each other.

MS. BELLA: Now, I have an all-new appreciation now for those two parties. Last week I was ready to nickname. We weren't going to be 2602 anymore. We were going to the Office of Interpretation and Translation, because it really is just translating some of these things.

Talking about swapping one or the other is beyond my purview. I can say I've been in both conversations, which is, let's give it to the states, and the strongest argument to give it to the states is they know how to do long-term services and support, and that's hasn't been part of Medicare's world.

The argument one give to the feds is, look at some of the -- and I say can this because I've been there -- things states have done with some of the financial things. Not to say that those loopholes exist today, but they create a long -- people don't forget those things, so there's such a distrust of states and the Medicare Trust Fund dollars that we have to get beyond that.

I think the reason you see some of the differences around managed care is just there is a belief that we

haven't seen a lot of good reason to mandate enrollment into these products. And absent these superior mechanisms, then why are we going to mandate enrollment? And I think that is -- so there have been different experiences in both programs.

We're not going to get to it anytime soon, you know, the federal takeover or state takeover, unless maybe you all have the power to make that happen. I know we're not going to be making that happen. But I do think there is an openness to trying to test new things, including an openness to try to understand how to be more favorable toward more organized systems of care. But in CMS, that doesn't necessarily translate into capitated, you know, traditional capitated managed care.

The more outcomes we get that show that these programs are making a real difference and beneficiaries are happy and we see beneficiaries choosing and providers not telling them to dis-enroll, that starts to build a better case. We have far too many providers, even on the Medicaid side, that tell people to dis-enroll. I'm not sure why that is. I know why part of that is, but that's an issue.

COMMISSIONER HOYT: I was just basically wondering

whether there's -- you have the statutory barriers and all the other things you talked about, but it felt to me like there's a philosophical barrier. I hope I'm wrong on the Medicare side. It's like, well, okay, but I just don't like it. You know, you talk about winning over their hearts and minds in other contexts, and it's felt to me like we're just not convinced.

So it just seems odd where you have the Medicaid side of the house, over and over, approving funding of different waivers and different things that have been tried on the Medicaid side, but on the Medicare side, it just feels like their heels are dug in and, I don't want it. So it's just kind of hard sorting that out.

COMMISSIONER RILEY: I'm struck for the Commission, as we think about this, when you think the ramp to 2014, we're a state that's been covering childless adults for a long time. A disproportionate number of them are behavioral health, pre-duals, and the kinds of people in the waiting period who, when every state is covering them, if we don't find a better way to manage their care between now and 2014 to get us on that glide path, we could have some really extraordinary costs and challenges for the states.

So it strikes me that that area of the under-65 duals who are driving costs may have the most promise for us to really focus our work.

COMMISSIONER CHAMBERS: I just wanted to follow up on Mark's comments. It is my frustration over the years of working at CMS, and the same thing that Mark talked about, was that since the first Reagan administration, then HCFA and now CMS, approved waiving freedom of choice for Medicaid beneficiaries when there was appropriate systems in place where they felt that it was okay as to require enrollment into organized delivery systems.

Whereas, the same beneficiary with the Medicare benefits is the same agency doesn't think that if the same protections are put in place as to why they can't require mandatory enrollment into organized systems care. I think that's always going to be a weakness, as long as that side of CMS continues to dig in their heels, as Mark says, it seems to be -- you know, we can't take freedom of choice away from someone, as I think freedom of choice should always be a premise of it should be there, but there should be where there's good systems of care as an alternative that Medicare should look at that option. My two cents' worth.

MS. BELLA: I don't disagree with that observation. That's incredibly odd that for one person, half of them can be mandated into something and half of them cannot. It's very bizarre. I would suggest that if you look at best practices, one thing the Commission might want to look at is the one time they did give some flexibility on that with passive enrollment, and understanding that there are pieces of that that worked well or didn't, I will say, unfortunately, the problems of a couple of states, one big one, colored the experience for all of it.

But I think there are some things that went well in that. That might be something that you all might want to look at in terms of helping move larger numbers of people into organized systems of care.

CHAIR ROWLAND: Melanie, to what extent is the Department engaged in a systematic evaluation of the SNP program and how well that's actually working? Because my understanding is that there's a lot of confusion about how well the SNPs actually fare with this population.

MS. BELLA: We are still talking with our colleagues on the Medicare side of the house to understand all the different initiatives underway to try to assess

what's going on with the SNPs. So I will have a better answer for you once I have a little bit more comprehensive look at that. I know there's a lot of interest and activity around using the models of care information.

All the SNPs soon will have to do the NCQA reporting. So there is definitely a process in place. Exactly how much we have today I'm still trying to learn that myself.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: I guess just to sort of close the loop on the train of thought that I started, if there are a couple of fundamental questions that you might say the Medicare side, if we can phrase it that way, is unconvinced of yeah, I looked at all these previous studies or I'm aware of those, but I'm still just not convinced this works or that that's a problem and maybe that's something we could help with. I don't know.

I think as long as there's philosophical opposition to doing certain things, even if you fix the other things, it's still going to be difficult.

MS. BELLA: Maybe a question back to Dr. Sundwall or Richard. I mean, the professional organizations seem to

express a different level of support about managed care on the Medicaid and Medicare side, so I don't know enough about that to know if that's part of the issue.

But I would say that's where there's a little bit of a disconnect, too, which the Medicare side of the house hears probably a little bit more from the professional organizations or they have a little more influence side than on the Medicaid side since there's so many different states. But that would be one thing that I would think is different, even from the same organizations.

CHAIR ROWLAND: I certainly think you've raised a lot of the issues that we're going to have to work with MEDPAC on, with you at CMS. We've just started this dialogue and we've just started our analytic work in this area. I think we'll try and answer some of the questions that you have. I think you should take David's invitation to give us some input on where you think some of the barriers are that we might focus on and address. We know you'll be back often with us, so we thank you for your time today, and Christie for her opening comments.

MS. BELLA: Thank you.

CHAIR ROWLAND: And now we'll take about a 15-

minute break.

[Recess.]

CHAIR ROWLAND: It's time to get back to work, and we're pleased to have joining us for this part of our discussion Deborah Bachrach, the senior program consultant for the Center for Health Care Strategies and the former director of Medicaid in the state of New York, who has been doing a lot of work on looking at the payment issues in Medicaid, obviously a central issue to the work of this Commission. And so we welcome Deborah to share with us some of her insights and her work on looking at these challenges, and then we'll open it up to discussion.

So, Deborah, welcome.

FRAMEWORK FOR REVIEWING PAYMENT ISSUES IN MEDICAID

* MS. BACHRACH: Thank you, Diane. I am both honored and thrilled to be here and thrilled that you exist.

I became a payment dork probably 20 years ago, and I spent about 14 years representing Medicaid-dependent providers and plans and walking them through New York's very complicated payment methodology so they could figure out how to maximize their revenue.

In January of 2007, I had the opportunity to

become New York State's Medicaid director and spent the next three years analyzing our payment policies, both our payment methods, our payment levels, both in the acute care sector and the long-term care sector. And I can say that, without exception, every single one was flawed, and we made enormous progress on the acute care sector, which is where we'll focus today.

Since leaving state government in January, I've been working with the Center for Health Care Strategies on Medicaid payment reform, and particularly on the fundamentals of Medicaid payment. And I've had the opportunity to work with other states and also with CMS.

What I want to do today is look at where states are, and I'm going to start with providing some construct for evaluating where states are, looking at the different state methodologies, and then some of the challenges that states and really CMS face together in ensuring that Medicaid is a sound purchaser of care, which, of course, is absolutely critical today with the states facing enormous budget constraints, and even more critical in 2014 when millions more people come into Medicaid and Medicaid becomes the nation's largest insurer.

So, in my view, where this discussion has to start is with federal law, and as I went back and had the chance to really dig into this, federal law is actually quite good, so our overarching payment standard is solid, and it has three elements. What the Social Security Act says is that state payment methodologies must safeguard against unnecessary utilization, must be consistent with efficiency, economy, and quality of care, and state payment rates must be sufficient to enlist enough providers so that Medicaid beneficiaries have the same access to care as others in the community.

Now, I know there's a lot of focus now -- and it's important focus -- on the equal access prong, on Medicaid beneficiaries' access to care, and that tends to focus on payment levels. All important, but I really want to urge that we not forget the first two prongs, which really talk about the method of payment, and that's where I found New York and many states are really backwards, really need help. And so I think we have to link payment levels, which tends to be synonymous often with access, but also we have to look at the methods, which I think are key.

This is the overarching statute. There are very

few regulations under that statute. Probably the most prominent are the upper payment limit regulations which govern sort of the most that a state can pay. So the bottom line is states have considerable flexibility in rate setting, and what this means is each state sets its own payment methods, and then they take it to CMS, CMS reviews it, and approves or disapproves it.

While states have a great deal of flexibility and while there are very few regulations interpreting Section 30(a), I think that we can all agree there are some basic fundamentals about what do you look for in good rate settings. And these aren't particularly controversial, and I'm not going to go through them other than the first one, which is transparency. In my view, that's utterly key because if we're spending billions of dollars as government, state government, federal government, we need to know what we're buying. And if the methodology is opaque, we don't know what we're buying. If the methodology is opaque, providers can't respond. So we've set up a method that wants to incentivize a certain kind of care; but if a provider can't understand what that incentive is because it's so complicated or, worse yet, we have conflicting

incentives, it doesn't work. And we can't report pricing data, we can't report quality data if we don't have transparent, straightforward methodologies. And I think that's utterly key.

I want to focus on fee-for-service payment methods, and there's a lot of talk now about bundled payments and accountable care and global payments and medical homes. But at the end of the day, they're all built off of a fee-for-service system. And beyond that, in Medicaid, 80 percent of our care is still rendered and paid for fee-for-service. And even where we have robust managed care programs, as in my state of New York, we still cross-walk back to fee-for-service methods and payment levels. We do and the plans do.

So fee-for-service can't be ignored. We can't just jump to those sort of sexier new ideas of accountable care or global payments. And when we look at fee-for-service, again, there are certain elements that are good and certain methods that are good and certain methods that are bad. And we know these things now. We know that institution-specific cost-based rates do not encourage efficiency. They encourage more costs. We know that if we

pay based on a per diem or a per hour, we get more volume. And we also know that payment levels influence access. But it's not just the absolute payment level; it's also relative payment levels.

In New York, we overpaid for inpatient alcohol detox, and we had more inpatient alcohol detox than any other state in the nation, because if you're a provider, what do you do? You chase the dollars, and we put the dollars on inpatient detox. We changed that.

So I'm going to focus now on hospitals and take the principles and apply them to the hospital sector, one, because we have more information on hospital payments than we do on any other sector; and, two, because Medicaid pays more for hospital services than it does for any other type of service. In fact, I saw an interesting statistic that the federal government pays more for Medicaid hospital services than it does for Medicare nursing home services. So how we pay hospitals matters a lot.

When we talk about paying hospitals, I think it's important to remember that Medicaid is different than Medicare. Almost half of our payments for hospital services are pediatric care and maternity care, and we have

substantial costs in the behavioral health care. So we look different than Medicare, and we are very important.

Now, let's cut to the chase. What are states doing, how are states paying for inpatient hospital care? Again, to put it in context, let's look at Medicare. We know that 27 years ago Medicare moved off of paying institution-specific cost-based rates, and it moved to DRGs, paying based on a discharge. You paid for a discharge, not a day, not for costs. And all of the literature tells us this is the most successful payment reform ever. It incents efficiency. Hospitals are getting a certain amount for the admission, and then they work hard to bring in their costs below that amount. But it also enabled access because it pays more for higher acuity patients.

What do we know about the states? We know that a third of our states, just short of a third do not use DRGs. They are continuing to pay based on institution-specific cost-based rates. We know that nine states are paying per day, and in many of those cases, they pay per day based on institution-specific costs. So we have at least 14 states that have not moved to what is universally acknowledged as the most effective way to pay for inpatient care.

Now, in some sense, this is the downside of state flexibility. State flexibility allows for experimentation. On the other side, what you see is state flexibility requires states to reinvent the wheel 50 times. And so a lot of states do turn to Medicare DRGs, but even there the problem is Medicare DRGs were formulated based on the Medicare population where you have very, very little pediatric and obstetric care and less and different behavioral health care.

As we're trying to understand inpatient payment methodologies in the states, it is made even more opaque or confusing or difficult because of this supplemental payment. So I can tell you that there's a state that's taken a Medicare DRG; they've modified the case weights to reflect the Medicaid population; but I can't follow it because they've got seven different add-ons, which we can call a DSH payment, we can call a UPL payment. It doesn't really matter what we call it. They're all legal. But they make the payment methodology more opaque, and I'll come back to that later on.

On outpatient payment methods, 50 percent of the states are still using institution-specific cost-based

rates. Half of the states are still doing that. We have 13 states that are using a fee schedule with virtually no bundling of services, and the more we effectively bundle, the more we incent efficiency. So we have half of our states that are still cost-based; 13 with a fee schedule, with no bundling or virtually no bundling; eight states have followed Medicare's lead and use APCs; and three states are using ambulatory patient groups, or APGs. New York went from a per visit methodology, fixed amount for every visit, to APGs. I personally believe this is the most dynamic methodology, but whether you agree or disagree, I think that it's clear that when we have half of our states still using cost-based methodology, we have a problem.

So now I've been talking about payment methods. I want to talk about payment levels. And, again, it's different in every state, and this is a tricky one. On some level, payment levels are driven by budget constraints and stakeholder advocacy. Some states simply use what Medicare pays, and that's what it's linked to. And in others, it's linked to federal funding opportunities. This comes back again to my supplemental payment. So payment levels are a tricky issue. It relates to the complicated issue you're

looking at of access. It's different in every state, and other than the UPL regulations, there is no federal guidance on how states should set payment levels.

Now, let's come back to supplemental payments. My presentation here is going to be, I think, somewhat critical, so I want to start by saying supplemental payments -- DSH payments and UPL payments -- are a critical revenue source for our safety net hospitals. And so as I'm critical of these payments or pointing out some flaws with them, I also think we need to be mindful that they are an important revenue stream, and certainly with DSH as intended to support safety net hospitals. But DSH and UPL payments are -- there are some federal parameters that set the maximum amount that can be paid, either to a group of hospitals or on a per hospital basis. But for the most part, how states pay these out are opaque.

They are often paid out as a lump-sum payment, unconnected to any of the services provided, and even when they're paid on a per discharge or per visit basis, there is no relationship to a specific patient or the specific care that is rendered. So the bottom line is that these supplemental payments, which are not an insignificant amount

of money, can distort very sound payment methodologies. And this is an area which clearly warrants further review.

CHAIR ROWLAND: Deborah, would you take a minute to just explain a little more about the difference, what DSH is versus upper payment limit?

MS. BACHRACH: Right. I'm sorry. I'm never quite sure how far to go on this, so let me step back and do a little bit.

DSH is disproportionate share hospital payments, and states are required to take into account the additional costs of disproportionate share hospitals, hospitals that serve disproportionately large numbers of low-income and Medicaid patients.

Upper payment limit payments are payments that are the delta between what a state is paying under its Medicaid program and what Medicare would have paid. So if my total inpatient Medicaid payments are $2 billion and Medicare would have paid $3 billion, I have a delta of $1 billion that federal law permits me to pay out virtually any way I want to the category of hospitals that created that delta. And I can make all of the payment to one hospital in that group or spread it evenly among all of the hospitals in the

groups. The groups are state-owned hospitals, non-state-owned public hospitals, and voluntary hospitals. And so that is my UPL payment, and it can be paid on the inpatient or the outpatient side.

My DSH payment is also a delta between what hospitals' costs of serving Medicaid and uninsured patients and what Medicaid pays. I do have an individual hospital cap in DSH. I can only pay it on the inpatient side. But it is relative to the hospitals' costs, be they efficient or inefficient. And if we decide that we will lower a payment to a hospital because they have high levels of potentially preventable readmissions, do I come in at the back end and make it up through a DSH payment?

And so I think that should be enough to give you a sense of these are legal, but they distort sound payment methods. And the other point I should make here is that the non-federal share of DSH and UPL payments -- both are Medicaid payments, so the non-federal share, the state's obligation -- is frequently funded through assessments on providers -- the hospitals are assessed -- or through an intergovernmental transfer. New York City or a city will transfer to the state the dollars to cover the non-federal

share.

Now, there are federal rules on how to do this, but they can be done -- you can't promise Provider X they'll get back the same or more money. But the more the non-federal share is funded by entities outside of state government -- local governments, or providers -- the more those providers in particular have leverage to influence how these payments are made, thereby further, potentially, distorting the payment methodology that a state adopts. All of this is legal.

VICE CHAIR SUNDWALL: Deborah, just a very quick question on that. Is the Medicare rate the ceiling? Or did you say they're actually cost-based reimbursement?

MS. BACHRACH: It's either. In the UPL payments, it's either. So your ceiling is either what Medicare pays or the costs of the segment, the providers in the group.

What states will do is if they want to hire UPL, they'll run both, and they'll say, well, we're higher at cost, and then we can make UPL payments up to providers' costs. Or they'll run the Medicare, and they'll pay up to Medicare. So it's an option. In DSH it's not an option. It's provider costs.

So states face enormous challenges in crafting sound payment policies, and when I first drafted this slide and had Lu and her staff look at it, there were about seven more bullets. So we tried to get it down to just a few of the key challenges. And I think the first challenge really goes back to Medicaid's roots in welfare. You know, when Medicare was established in the 1960s, it was given to state welfare officials. It was not given to the insurance agencies or to the Blue Cross plans. It was given to welfare officials to run. And it was run as a small poverty program. We didn't have a lot of data in the 1960s or the 1970s or in the 1980s. And so then really the notion of effective purchasing, it took many, many years to bring Medicaid into -- and it's still moving in that direction -- the notion of being an effective purchaser. By 2019, Medicaid will be the single largest insurer in this country, so it's the right track.

So we start with our roots in welfare. We have a system of -- we have a partnership with the federal government, and it has benefits, but it can also be an awkward partnership. And state payment policies in the first instance have been left entirely to the states. And

as I said in my presentation, Medicaid payment is really complicated. I mean, I really think it's like rocket science. And we're asking each state to do their own thinking on what's the best payment method for inpatient care, for outpatient care, for home care, for long-term care, for Medicaid managed care. And that's hard. And we can't entirely rely on Medicare, and state resources have always been limited, and they are especially limited now.

So each state has to develop their own policies, subject to their own local political pressures, and then go to their own, if you will, regional office of CMS who reviews what the state has done. It is an awkward system for such a complicated area.

And then, as I said, Medicare is a benchmark -- not a perfect benchmark. We have -- and you know this -- no national Medicaid data to compare to. In my role at CHCS, we had a small meeting last week with a handful of state Medicaid officials and CMS officials, and we had both the Medicaid director and their chief finance people there, who were incredibly impressive. They had never met each other. There is no forum for the top state finance officials, the folks charged with thinking about this to work together. So

we really are reinventing the wheel 50 times. We're doing it under enormous fiscal pressures, and we are doing it in communities in 50 states where the local stakeholders are deeply, deeply vested in payment decisions.

I will say that I was out in Wisconsin where they're looking to change how they pay for outpatient care, and I was blown away by two features out in Wisconsin that don't exist in Illinois, which is where I had just come from, and New York, where I spent three years. One is they have a two-year budget. We have a one-year budget in New York. It is very hard to do a Medicaid payment strategy with a one-year budget lens. Twelve months we have to think about it. That's enormously difficult. The other relatively unique feature in Wisconsin -- and certainly different than New York and Illinois -- is that in Wisconsin the authority to set rates is vested in the state Medicaid agency and not in the legislature, which does not insulate it from stakeholder pressure, nor should it, but it is a very different dynamic than having rate-setting methods and rate-setting levels established by the legislature. So the challenges states face are really enormous.

So how do we think about this going forward? And

how do you think about it going forward? I think that with Medicaid on the verge of becoming the nation's largest insurer and the federal government's share of Medicaid spending about to go up dramatically, and Medicaid already the largest item in most state budgets, we've got to get it right. So what do we need, what do the states need -- I still think I'm a state, but I'm not. What do states need to get it right? And one is additional data, and I think that's the question, what additional data and what additional analytics, and what technical assistance or guidance. And this is one question, but in some sense it's two issues.

One is what additional guidance, potentially regulations or state Medicaid director letters from CMS, and what additional technical assistance do states need to get it right, because every state wants to get it right. And then what are the benchmarks? As I've said several times, Medicare is a good starting point, but I don't think Medicare is necessarily the best starting point.

As we begin to get our arms around the payment methodologies and begin to think through how we can really states and the federal government together can do a better

job, we're going to have to come to terms with these supplemental payments, because, again, we need to understand what state practices are, and we need to think through what our goals are and how they can be achieved. And all of this is made even more important with the Affordable Care Act, of course, reducing the amount of DSH payments that states can pay, which makes it more important that we get it right on how we pay it out.

So thank you, and I will answer any questions.

CHAIR ROWLAND: Thank you. Mark?

COMMISSIONER HOYT: No, you go first.

CHAIR ROWLAND: Andi?

COMMISSIONER COHEN: Hi, Deborah. Thanks for your presentation. It was great.

MS. BACHRACH: Thanks.

COMMISSIONER COHEN: So I am very interested in this issue of how do you think about providers who are very dependent on one funding stream, or one or two, and providers that have many and therefore have many different incentives to respond to? I remember I was speaking to a friend of mine who works for a commercial insurer and she happened to mention that in New York, they still pay some

hospitals on a per diem basis and some not, and just sort of it seems like the methodologies are sort of coming sort of all over the place.

So I guess that leads to a number of questions, but one of them is is there any research or experience that can help us to understand what threshold of a particular payer for any particular kind of provider do you need to meet before payment methodologies can really affect their behavior one way or the other and how can we think about that, because we are triaging a lot of extremely challenging issues, and in a perfect world, all payment methodologies would be the most sophisticated and the best targeted. But if we need to sort of pick some earlier topics, I think we want to pick things where we can have maximum impact in a change in policy.

So one question is, how do we think about the issue of aligning -- when you don't have alignment of payers, where Medicaid payment methodology changes can make the biggest difference and how can States think about that. So that's sort of one question. Is there any research that says it has to be -- once a payer is 50 percent of your revenue, small changes can have a huge impact on your

behavior. Are there any benchmarks like that?

MS. BACHRACH: Well, I think I want to answer it in a couple of ways. One of the points that I didn't make that I want to make, and it comes to something you're saying, is that one of the reasons Medicaid has to be smarter about how it pays is because we know that we have to align with other payers. If Medicaid goes to the left and Medicare goes to the right, providers can't respond to those incentives. I'm not answering your question, but I think that's another reason why it's so important that Medicaid upgrade its payment methods and come more in line with other payers.

Now, the question you asked is something we struggled with a lot in New York. At what point does Medicaid matter, if you will? If I'm five percent of a hospital's payments, I'm much less important than if I'm 30 percent, and I'm not aware of any -- and Mark, maybe you know -- where it says, at this point, it's a tipping point and Medicaid matters the most. But we do know that we are a significant payer in some communities and in some providers, and if Medicaid agencies aligned with the State health employee purchasing -- which is one of the things that we

found in New York, is the civil service that runs our State employee health wouldn't talk to us for years. It was, like, the unions didn't want them to talk to Medicaid. Don't play with Medicaid. That's that awful program for poor people.

And as we started to act like a purchaser, we developed very good working relationships with our employee health plan, such that -- and Andi, you know this -- we have a multi-payer demonstration in the Adirondacks, easier because it's a smaller area, not New York City, but we, the State, came in as Medicaid managed care, Medicaid fee-for-service, and with our employee health and said, this is how we want to pay, and we brought along the private payers and we're now hoping Medicare will come in.

So I think States have leverage that goes beyond Medicaid. I think States can't begin to use that leverage until they get smarter, and I don't know what happens at the point where our leverage is only the five percent and how do we think about it. But I still think it has to do with aligning with other payers.

COMMISSIONER HOYT: Yes. I was going to have to sort of challenge your concluding point. I couldn't help

but think about a Medicaid director I met with in the last month, and I believe this person has integrity, and he said, I have this huge fiscal nut, deficit, staring me in the place for fiscal year 2012 and I feel like we've done everything I can think of to do, and I feel like kind of a slimy weasel, but I don't have any other ideas except to do like a hospital tax or an assessment type of thing to load in. I need hundreds of millions of dollars. I honestly have no idea where I'm going to get it except to do that. And so, yes, I think he'd mostly like to get it right, but he's feeling like his hands are tied, and I'm guessing there's got to be a lot of people like that that are kind of stuck.

MS. BACHRACH: Your point is fair, Mark, and I sometimes tend to be a little more definitive than I should be. I think the provider assessments or provider taxes are absolutely critical, and I don't mean to suggest otherwise. In an era of scarce resources, using those assessments is absolutely critical.

I think what I want to do is just raise a red flag that says, in using provider assessments, we need to be mindful of how it plays out on our payment methodology. We

need to be mindful of how it plays out in terms of supplemental payments. But I'm not suggesting -- I mean, if provider assessments were not -- and more than 40 States use them -- were not available, we would be in much bigger trouble.

So again, I don't mean to speak against them. I guess I mean to raise a red flag. I will tell you, as I have been talking to Medicaid directors, and I was speaking with a Medicaid director who told me that their entire non-Federal share of their hospital payments comes through hospital assessments and they can't change it without the approval of the hospitals.

So it's not -- we've just got to get that balance right, and maybe some of it is talking about it, because I'm not always sure we can legislate it.

CHAIR ROWLAND: Robin?

COMMISSIONER SMITH: Hi. I'm learning so much. I'm the parent consumer, and I appreciate you being here today and sharing. Can you tell me, I'm interested in the DRGs. Is there a place, a website, somewhere that I can find the information on which States that you've mentioned, that five States are using one method, nine are using

something else? Is there somewhere I can find the information on what States are doing what?

MS. BACHRACH: In the article that I wrote that I believe was distributed, we do have -- there's a chart in there for both inpatient and outpatient --

COMMISSIONER SMITH: Okay.

MS. BACHRACH: -- by States, and CHCS is doing a new article which will update that in the next couple of weeks.

COMMISSIONER SMITH: Thank you.

CHAIR ROWLAND: Trish?

COMMISSIONER RILEY: I'm really struck with this whole approach to payment reform for our deliberations and I think we need to really use this as our sort of focus. But I'm also struck with when you think about Medicaid and its spending, so much of it is on disability. So I think not first of hospitals. And we're a State that's only now -- it took us eight years to move to DRGs because of some information system issues.

But I'm struck with, when you look at -- you focus our attention on 1902, which I think is critically important. It reminds us that we have to safeguard against

unnecessary utilization and be consistent with efficient economic and quality measures. It seems to me that's a focus, particularly around our spending on disability, because we don't -- that is very much a black box for a lot of us, I think. What is the most appropriate utilization? What are the quality methods? Where is there evidence? Because there, there may, in fact, be savings that we can reinvest.

MS. BACHRACH: I think that's right. I mean, we decided to start with acute care because it's less opaque and we know more and I personally know more. But from my New York experience, I think the long-term care services, both nursing home and home health, or community-based services, are tremendously problematic. I can talk only to my New York experience, but we are still paying for home care on a per hour basis. We did a regression analysis and we found that the single largest determinant of how many hours a patient got of home care was what agency they went to, not their acuity but what agency they went to.

And as we're trying to get our arms around long-term care, and we're focusing on more community-based care, I think there's an absolute shortage of expertise and

guidance at the State level on payment for long-term care services, and I started out by ducking it because it's -- I don't get it.

COMMISSIONER WALDREN: Thank you very much. As one of the things we think about for home payment when we think about our March deliverable of our report, you know, payment is always a difficult nut to crack. At face value, you talked about the DRGs and the APGs and that there's not one specific for Medicaid. So on face value, it seems like maybe that's something we should look into. Could you talk maybe a little bit about do you think having those that are very specific to Medicaid diagnoses and based on that evidence, would that be a value and would States pick it up and do something there, or --

MS. BACHRACH: I think that one of the things that you might consider is when CMS went to MS-DRG several years ago, it specifically developed them for Medicare only. It could have developed them for a broader population which included Medicaid. And CMS is now looking at home health reimbursement again.

Why couldn't CMS do an all-payer approach so that it encompassed both Medicare and Medicaid, because I know

that in home health, when CMS went to episodic payment for Medicare home health, Medicare payments to our home health agencies went down and our Medicaid payments skyrocketed. I mean, it's what we call our "Jaws" chart. Why couldn't we be developing one payment methodology across the populations?

I'm not a payment expert, and I don't know, Mark, if you could speak more to this, but I just think it would be more efficient because CMS has as much financial stake in getting Medicaid right as Medicare. And that way, we wouldn't have to reinvent the wheels 50 times. Now, I may be completely wrong, so I'm a little nervous telling you this, but I think that's the kind of thing we ought to be thinking about and maybe something this Commission could be looking at.

COMMISSIONER MOORE: Deborah, thanks. This was really helpful. You mentioned just a minute ago the lack of expertise around long-term care, but this kind of boggles my mind in terms of sort of sorting out how we should proceed, particularly in the short run. And some of us who have been around this program for a while know that the Federal Government has no expertise in Medicaid payment. I

certainly remember, and I know from talking to Cindy Mann more recently that she's very concerned about that lack of expertise.

I guess I'm wondering if you have any thoughts for us about prioritizing or looking for that kind of expertise or developing it ourselves or just -- because I think a lot of us are concerned about variation, which you also mentioned, and giving more help to the States and more models that they can use, and I don't know -- this one's a bit harder in my view because there isn't as much expertise at the Federal level in Medicaid as certainly there is in some other areas.

MS. BACHRACH: Julie, I think you have hit the nail on the head. The way that Medicaid payment has been structured means that the Federal CMS staff have not -- don't have Medicaid expertise. The Medicare side doesn't have Medicaid payment expertise. And States have vastly different levels. And so in some sense, we're almost starting from scratch. There are some very smart people in the States, and certainly there are outside consultants. But I keep wondering, and in some ways I'm coming back to how I answered the previous question, can we build on the

Medicare expertise, because if the answer is no, then I think we have to build within CMS that kind of expertise because here, I think, States would like to see the expertise coming out of Washington.

You know, with payment levels, there's more flexibility. How you do a medical home model, there's more need to look at community and market differences. But what's a good payment methodology? Should I use APCs or APGs to pay for outpatient care or per diems or cost based or DRGs? I think that that's more of an objective standard where national guidance would be important.

And then on the question of framework for access issues and payment levels, I think we desperately need a framework from Washington. I think you can't be -- it's not -- there's no objective standard. You have to pay Medicare. That may not work. But I do think a framework would be important, because in the absence of a framework, you're trying to do this at the State level, or worse yet, you're trying to do it in the courts with providers litigating, and when it's in the court, it's a provider litigating. It's, "I'm not being paid enough," and the analysis is provider-driven, which is not -- which is a lens, but should not be

the only lens.

CHAIR ROWLAND: You know, it's sort of an interesting history. At the beginning, Medicaid and Medicare had to pay the same for hospital care. And then when DRGs came into effect, the States said, no, we are afraid that will make us pay more than we can afford, so they were given authority to have their own separate payment systems. And they always have authority over the physician payment area. And now with the Accountable Care Act, we're coming back to say, no, you've got to pay like Medicare, at least for primary care.

So I think one issue is really to look at where there should be synergy between the two programs and where it makes sense to have more discretion at the State level. But there's a lot of circling back and forth here on the payment policy.

MS. BACHRACH: I actually did note that, about that historical point that they were tied, and I think that's right and I think that it's both method and level. I think that's what I want to leave with, which is we have to remember that method matters as much as level and that there may be different approaches, but we can't do one and not the

other.

COMMISSIONER GRAY: Do we know why those States, those 14 or so States that don't use DRGs, why? Is it purely political? Is it technical? Is it a mish-mash of --

MS. BACHRACH: Well, I asked a former Medicaid director in one of the States who's very good, and the current Medicaid director is very good, and he said, you know, we know it makes no sense, but if we go to DRGs and if we hold the budget neutral, we will have a tremendous reallocation of resources. And since we have no additional dollars, reallocating resources among and between providers when we're already paying too little is just not something we can accommodate. So, you know, each of these methods grew up over time and it's harder to unwind than it is to wind up, if you will.

COMMISSIONER COHEN: Can I ask one last quick one? So on -- you know, I understand your point very well about DSH and UPL and how add-ons don't tend to get as much sort of analytic as the underlying rate, even if the rate gets good. But I guess my question is, clearly, there's a difference between what I'll call like Medicaid-dependent providers and others in terms of how Medicaid does need to

think about paying them, and the mechanism currently typically is to use DSH or UPL. But what would be -- and to do it in sort of these lumps. But what's a better way?

What's a better way to make some distinction between what they call Medicaid dependent or safety net, like the providers that we need to keep around but really -- or we think -- some people think we really need to keep around, and yet they don't have the same sort of revenue sources as other providers. And I'm not just talking about hospitals. How do we make those distinctions? Is the Federal Government capable of making those distinctions if there was sort of a Federal model? I mean, I think that's a huge thing that we have to grapple with. What's a smarter way to recognize their essential existence than we currently do today, because certainly just getting rid of those add-ons or redistributing them across all providers, it seems you could really be throwing out the baby with the bathwater.

MS. BACHRACH: I agree. I think the first thing we have to do is bring some transparency to bear. We do not know how these dollars are being allocated. Even before we get to the issue, we don't know how they're being allocated.

Are they being allocated based on, my favorite, units of service to uninsured patients? I mean, are they -- and this is a discussion we've had in New York. As a starting point, and this becomes even more important in 2014, where are our uninsured patients? Where are the remaining uninsured getting care, and should that be the first draw on the DSH payment?

Then there's the second question about what are the other additional costs of serving very large numbers of Medicaid patients. How do we quantify it? What are they? And then how do we pay for it appropriately without undermining the payment method and the payment system we've put into place? But it all comes back to better understanding what we have now and a level of clarity that we absolutely don't have now.

CHAIR ROWLAND: Well, Deborah, you've given us a lot to think about. It clearly is central to our agenda to look at all of these issues. I think this has been a great starting point, so thank you very much.

MS. BACHRACH: Thank you.

CHAIR ROWLAND: And we'll stay in touch --

MS. BACHRACH: It's been a pleasure.

CHAIR ROWLAND: -- and look forward to working with you.

MS. BACHRACH: Thank you.

CHAIR ROWLAND: And now if this issue wasn't complicated enough, we're asking Patti to come up and to kick off our discussion of payment for drugs in Medicaid, so just one type of services, but Patti Barnett has put together some of the first-level analysis that we'll do on trying to understand how Medicaid pays for drugs and all the complicated issues of things like rebates and whatever. But she's keeping it very simple, so we're looking forward to engaging in this piece of our debate.

Thanks, Patti.

STAFF BRIEFING: BACKGROUND ON PAYMENT FOR DRUGS IN MEDICAID

* MS. BARNETT: Thanks, Diane. It's a pleasure to be here.

Today I'm going to be giving you a presentation providing some background on payment for prescription drugs in Medicaid, and I'd like to begin by reiterating what Diane just mentioned, that this is complicated stuff. It's not for the faint of heart. But it is a starting point, and I

look forward to your suggestions and feedback on areas that we might look into further at later meetings.

It's an important issue to address. As many of you know, prescription drug spending has been a growing cost to the states and the federal government. And in our discussions with states, many have noted the challenges they face in setting payment rates to pharmacies and managing their drug benefits, particularly drugs for special needs populations.

Today I'm going to cover the four major policy drivers in Medicaid prescription drugs. The first is how states pay pharmacies in a fee-for-service setting. The second I will address is federal efforts to set a maximum federal reimbursement to states, known as the federal upper limit. The third will be a very broad and high-level overview on the Medicaid drug rebate program which has played an important role and has generated billions of dollars in savings to the states and federal government. And, lastly, we'll look at some tools that states have used to manage their pharmacy benefit.

As we're going to through these policy drivers, there are some key questions on the state payment to

pharmacies. What is the true acquisition cost of drugs? And how can states set accurate payment rates?

With regard to the federal upper limit, what is the maximum the federal government will reimburse state for drugs? With regard to the rebate, what are the rebate requirements for manufacturers and what are the issues there? And, lastly, what are the tools that states are using to manage their pharmacy benefits?

Just a little background. Medicaid prescription drugs is actually an optional benefit, but all states have elected to provide. States can design their benefit under broad federal guidelines. They can development preferred drug lists and exclude certain drugs that are outlined in statute.

A major change occurred in 2006 when dual eligibles shifted and began to receive their drug coverage in Medicare Part D. While state Medicaid programs are no longer providing drug coverage, comprehensive drug coverage to this group, states continue to contribute towards these costs through what are known as clawback payments.

Prescription drug spending has been a growing cost to the states and federal government over time. In the

1980s and 1990s, there was double-digit average annual rates of growth, and during that time the federal government took steps by creating the federal upper limit and the rebate program.

As you'll see, between 2005 and 2006, there was a drop in spending. I want to note that that drop does not reflect the payments that states make, the clawback payments that states makes.

Most recently, drug spending has been rising. In 2009, it was 9 percent higher than 2008. While some of this is enrollment driven, there are some underlying cost factors such as advances in drug treatment for chronic care conditions, high-cost drugs for special needs populations; and overall, prescription drugs account for 45 percent of total Medicaid expenditures.

Medicaid continues to be a major purchaser -- 4 to 5. Sorry. Yes, 4 to 5 percent.

Despite the shift of drug coverage for the duals to Medicare Part D, Medicaid continues to be a major public purchaser of drugs in the U.S. market, accounting for about 8 percent in 2008.

The first policy driver I would like to talk about

today is how states pay pharmacies. A beneficiary goes into a retail pharmacy to fill their prescription. They may pay a nominal co-pay, and then the state pays the pharmacy.

The payment consists of two components. The first is the cost to cover the acquisition cost of the drug, which is known as the ingredient cost. And the second is a reasonable dispensing fee. The federal government shares in these costs, and states can set these rates under broad federal guidelines.

One of the biggest challenges that states face is determining how they're going to pay pharmacies. They lack data on the actual acquisition cost of drugs. That data is mostly proprietary. It has generally been confidential. And so states instead rely on published prices, known as average wholesale price or wholesale acquisition cost. Payment rates vary widely across states, but generally have been an AWP minus a flat percentage.

As the Health and Human Services Inspector General has noted, AWP and wholesale acquisition cost do not usually reflect pharmacy costs for drugs and have noted some concerns with using these published prices as a benchmark for payment.

In addition, there was recently a lawsuit which found that AWP prices were inflated on about 400 brand name drugs, and a major publisher of AWP has agreed to stop publishing these prices by September 26, 2011. While other entities might publish this data, the concerns outlined by the Inspector General and also this lawsuit have made states start to think about what is a good benchmark for setting prices and what can they do in this area.

I just would like to note that recently the state of Alabama received approval from CMS to change their pharmacy rate from an AWP-based or WAC-based price to an average acquisition cost based on surveys of states.

The second policy driver are federal efforts to rein in spending through the federal upper limit. As I mentioned before, the states pay the pharmacies, but the federal government shares in those costs. That reimbursement is subject to the federal upper limit, and what it did -- and it began in 1987 -- it caps the amount paid to states for drugs with generic alternatives. The intention is that the cap is set closer to the generic market price, and by doing that, the idea is to encourage greater generic utilization at the state level and also for

states to set their payment rates in line with that federal upper limit.

The original federal upper limit was based on lowest published prices, such as AWP and WAC. But as I noted in the discussion on state payment policies, the IG has noted concerns with using this benchmark and has found that with this federal upper limit, the federal government was overpaying for drugs.

In fact, another interesting point here is that states have developed their own federal upper limits at the state level, which are called maximum allowable costs. About 45 states and the District of Columbia, I believe, have those programs.

Due to the concerns from the IG, Congress took some steps to address these concerns through the Deficit Reduction Act. It changed the FUL from published prices to average manufacturer price to better reflect drug acquisition cost. And just a little definition, which you can see on the screen, AMP is the average price paid to manufacturers by wholesalers, and it's based on actual sales.

However, there was a concern among retail

pharmacies that this FUL level was too low and did not adequately cover their retail pharmacy costs. In addition, retail pharmacies filed suit in U.S. district court, and there's currently a preliminary injunction from CMS taking any steps to implement the DRA FUL. And if the story isn't complicated enough, the Affordable Care Act made yet another change to the FUL and changed it to a weighted average manufacturer price as an attempt to address some of these concerns.

The third policy driver is the Medicaid drug rebate program which was established in 1990. I'm going to provide a very broad, high-level overview, and I hope that I can come back, if I haven't bored you enough, and outline some of the issues in this area.

The goal of the Medicaid rebate program was for Medicaid to receive similar discounts afforded other large consumers. At the time Medicaid was the largest public purchaser of drugs. And in order for a manufacturer to participate and have their drugs covered in the Medicaid program, they must sign an agreement with the Secretary and in exchange pay rebates.

In 2009, there was about $9.7 billion in total

rebates collected, which decreased drug spending by about 38 percent, so it's pretty sizable. And this also includes some additional rebates that states have negotiated on their own.

The rebates are based on formulas for brand name and generic drugs, and previously the rebate program only applied to drugs provided in the fee-for-service setting, but the Affordable Care Act extended those rebates to drugs provided in managed care settings. And the Affordable Care Act also made some other major changes to the rebates, increased the rebates, and I can get into that in greater depth at another time.

Lastly, the fourth policy driver are tools that states and the federal government have used to manage their pharmacy benefit. A number of states have implemented preferred drug lists. About 45 states and the District of Columbia have done so, and they vary in their development. Some have used contractors to develop their list of cost-effective drugs. Others have used research collaboratives. One important research collaborative is the Drug Effectiveness Project -- or Drug Effectiveness Review Project, which is sponsored by the state of Oregon, and

about 11 states participate in that, and the Canadian government.

The other major tool that states have used to manage their pharmacy benefit are required generic substitution policies. And, lastly, another major one is the Drug Utilization Review activities, which started in 1990, and states do utilization review at the point of sale and also post-utilization. And, in particular, there has been a special focus on drugs for special needs populations, and in particular looking at high-cost drugs and the area of mental health.

So now that I have run through the four major drivers, we outlined some issues for further consideration, and I'd welcome your feedback on these.

The first with regard to the state payment to pharmacies, with the issues with AWP, what are some possible price benchmarks across the states? And what are they considering?

A second is looking at the federal upper limit and thinking about the impact of the new Affordable Care Act FUL level. How does it compare to acquisition cost? How do the levels compare to the state maximum level cost programs?

And, lastly, looking at tools to better manage pharmacy costs, a couple suggestions in this area, looking at state preferred drug list efforts to the extent that some states are using clinical research and development of their PDLs.

Another issue -- and this is, I think, important given the ACA change to extend rebates in managed care -- is what's the impact of -- what are the impacts of managing drugs in a managed care setting versus a fee-for-service setting? And a number of states have carved out drugs, some for special populations, some for their entire population. So it will be interesting to see with rebates being provided through managed care settings, will more states carve back in those drugs, and that would be an area for evaluation.

And, lastly, focusing on those high-cost drugs, particularly for special needs populations, that has been a major concern for states, and that's another area we could look into.

So I look forward to your feedback and comments on where we could go further with this area. Thank you.

CHAIR ROWLAND: And, Patti, just for clarification, the Accountable Care Act provisions you're

talking about don't have to wait until 2014?

MS. BARNETT: That is correct. The rebates were actually -- the rebate increases went into effect retroactively, January 1st of this year, and the changes in the FUL are effective this fall. And the change to provide rebates in managed care plans, that is also retroactively effective January 1st of 2010.

VICE CHAIR SUNDWALL: I just want to thank you for this. As a person responsible for a Medicaid program -- I am not the director. That's Michael Hales. But I can tell you I have scars on my back from hearings getting a PDL. It was something I committed to do when I started in 2005. I think we were the 38th state. We were kind of behind.

And, by the way, Trish Main was my big ally in that. I don't know if you know the conversations I had with the staff up there.

But it was remarkably difficult. PhRMA went to the mat and spent who knows how much money flying people in to testify against this, I think which is a statement about how much they felt they had at stake. But now that we have it, it really is remarkably helpful. We're documenting more savings than we even projected. We have carved out, if you

will, behavioral health. That was kind of a condition of getting it passed, was to -- some very effective advocates for the mentally ill to make sure we didn't make that a barrier. But now we have a vigorous legislator that I think will try and fold at least a tiered level of psychotropic drugs into our PDL.

But it is a challenge for those of us who have to run programs of the state, and as a clinician I can tell you it's my impression that there is significant overutilization of medications across the board, not just in the Medicaid population but probably more there. So this guidance that we get or can develop would be very, very helpful.

We also collaborate with the Oregon group on what drugs -- you know, using their science base on what we should do. So this is something that we really -- I'm glad we as a Commission are paying attention to this, but I think there are some constructive recommendations we could make on utilization that would be very helpful in the cost equation.

COMMISSIONER CHAMBERS: A couple of things. Delivering pharmacy benefits at the local level, as we're constantly struggling as managed care organizations, is the issue about the drug cost, the acquisition cost, then the

dispensing fee. And it seems to be sort of the old balloon where you squeeze one place and it just pops out someplace else.

But in that discussion, in our plan in Orange County, California, we have 450 pharmacy deliver sites. About half of them are chain drug stores; about half of them are independents. And there's always a lot of debate at the local level as what is the role of small independent pharmacies versus chains, where there's a big difference in cost. And it's the issue of, you know, what is an appropriate level of service for Medicaid beneficiaries, particularly language challenges, you know, ethnic challenges of is there a difference, and is there a difference between the type of delivery site that goes on. So what I'd be curious to know is where there's discussions and research on, you know, how we deal with that, because it really does impact the cost, because in our case, as the chain drug stores can deliver a more cost-effective product, but are we sacrificing the actual utilization of appropriate pharmacy benefits? Then I have a second statement, but go ahead, if you want to --

MS. BARNETT: No, no. Go ahead.

COMMISSIONER CHAMBERS: The second one has to do with the whole debate over the 340(b) program, and for those of us in managed care, I can't go to a conference anymore where a PBM is not selling how you can utilize or leverage 340(b) pricing for saving dollars, which certainly from a managed care perspective is you're always trying to find ways as to, you know, more cost-effectively utilize limited dollars that you're paid. But it seems to be something that I can't quite figure out, is what is the benefits of that, and should the general Medicaid population, either in fee-for-service or managed care, somehow be benefitting if the private sector being PBMs have figured out how they can earn you dollars, is that not being looked at as a broader policy question for Medicaid?

MS. BARNETT: Those are two excellent points.

On your first point on community pharmacies and the services that pharmacies provide, I think an area that hasn't received a lot of attention is dispensing fees and what are counted -- what are counted in dispensing fees and the professional services that are involved with filling a prescription, you know, sort of care management at that level. So I think -- and then looking at the role of

community pharmacies versus others, I think that's a really excellent point, and we can look into that.

And on the 340(b), I think that is another area that a number -- a couple of states have actually mentioned. They want to know more about it as well, and I think that would be a great area to look into.

COMMISSIONER CARTE: Patti, I know you're focused on cost and utilization, but there's one children's quality issue I'd like to mention. In West Virginia, we're reviewing the use of both psychotropics and ADHD drugs, according to the measure where, you know, physicians should be following up and seeing those children after they've been on drugs for a year before they re-prescribe, and sometimes that doesn't happen. It's just a really sensitive issue that I think bears watching.

CHAIR ROWLAND: Well, Patti, we know that you'll be back many times talking about these issues.

[Laughter.]

CHAIR ROWLAND: And we'll have a little cheat sheet with all the letters so that we can keep everything straight. But thank you for this opening discussion.

PUBLIC COMMENT

* CHAIR ROWLAND: Now we will ask the public, if they have any comments that they would like to offer to us, to please come to the mic and identify themselves and pose your questions.

[No response.]

CHAIR ROWLAND: You all understand how the drug program payments work perfectly. No questions.

Well, thank you very much for joining us at this meeting of MACPAC. We look forward to continuing to engage on these issues and to try and come to some conclusions about new directions for the program, and we'll look forward to seeing all of you again at our next meeting in December, on the 9th and 10th of December, at a location to be determined. So please go to our website and keep in touch. And we will have a transcript of this meeting posted at some point -- probably Tuesday or by the end of next week.

Thank you very much.

[Whereupon, at 12:07 p.m., the meeting was adjourned.]