MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

Meeting Room 103 (A/B)
Washington Convention and Sports Authority
Washington Convention Center
801 Mount Vernon Place, NW
Washington, D.C. 20001

Friday, February 25, 2011
1:19 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
BURTON L. EDELSTEIN, DDS, MPH
PATRICIA GABOW, MD
HERMAN GRAY, MD, MBA
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH

LU ZAWISTOWICH, ScD, Executive Director

P R O C E E D I N G S [1:19 p.m.]

CHAIR ROWLAND: If the Commission members could reconvene to the table.

Who is supposed to be at the table?

EXECUTIVE DIRECTOR ZAWISTOWICH: It should be April, Chris, and Christie.

CHAIR ROWLAND: So, April, Chris, and Christie, can you come to the table, please.

I want to call to order this session of the Medicaid and CHIP Payment and Access Commission, and we are engaged actively at this meeting and trying to come to some final conclusions to get a report that can go to Congress on the 15th of March that will contain our initial foundation framework for the work of MACPAC.

We have been actively discussing in all of our prior meetings the various topics that have been in our congressional authorize and are now putting together the final drafts for this report that will go to hopefully be printed in the next week so that it can make the March 15th deadline.

This morning, the Commission members who have been reviewing and the external reviewers that we have had comments from were assessed with a very technical review, including picking up the word "Medicare" where it should have been "Medicaid" and different notes and footnotes in this draft, so that we've looked at line-by-line edits. But what we want to really focus on now is the broad content of each chapter, asking the staff to just review what each chapter of the report will cover, and then to really talk about what that means in terms of the work of the Commission going forward.

So we'll start with really the overview of the report, and I think it's important for those in the audience to know that what we're envisioning for our first report to Congress is a Section 1 that will provide an overview of the Medicaid and CHIP programs, followed by a more detailed explanation

of those programs and their framework. And then we intend to look at issues related to access and a framework for analyzing our access-to-care work, issues related to payment, and a chapter on the beginning of our payment assessment, and, finally, a chapter related to the data that can be obtained through administrative data sources to be able to analyze and answer some of the key questions that Congress has put before us.

So to kick off our discussion of the first chapter, we'll turn to Christie. ###

OVERVIEW OF MEDICAID AND CHIP

MS. PETERS: Thank you. Good afternoon.

At our January meeting, where we discussed drafts for our first report to the Congress, you asked that the first section of the report be broken into three separate chapters: one for discussion of Medicaid and CHIP in the context of the U.S. health care system, one for an overview of the Medicaid program, and then another chapter for an overview of the CHIP program.

You asked that we emphasize key points throughout these chapters, including what these programs are, who they serve, how they fit within the U.S. system, the challenges these programs face going forward. You also asked that we discuss the program's complexities along with the basics, particularly with respect to state variability, program financing, federal-state relationships, and basically the need for the analytic work of MACPAC.

Chapter 1 of the report provides a brief overview of Medicaid and CHIP, highlighting the program's unique role in the health care delivery system, the challenges the programs face, and the establishment of MACPAC.

The chapter continues with a brief discussion on the history of health insurance coverage and the enactment of Medicaid and CHIP, including a timeline highlighting select legislative

milestones for the program.

The chapter then discusses Medicaid and CHIP in the context of the overall U.S. health insurance coverage and in terms of the share of total health care spending in the U.S., including spending by selected services.

The chapter concludes with a discussion regarding balancing federal and state priorities and the challenge program administrators face meeting these often difficult different responsibilities, particularly during difficult fiscal constraints.

Chapter 2 of the report is an overview of the Medicaid program and highlights program eligibility, benefits and cost sharing, federal and state financing, and program administration. Medicaid program waivers and 1115 research and demonstration projects are also described. Throughout the chapter, discussion of future issues, including the impact of the Patient Protection and Affordable Care Act on Medicaid eligibility, benefits, and provider payments, is presented.

Chapter 3 highlights key program features of the Children's Health Insurance Program; background information, including the program's history; and the impact of CHIP on coverage for uninsured children is presented, as well as information on program eligibility for low-income children and adults. Child enrollment data through FY2010 is provided in the chapter as well as child enrollment by family income.

Coverage and payment for benefits is explained, as are the various components to CHIP federal funding, including the federal allotments, the redistribution of unspent allotment funds, the new contingency fund for states with CHIP funding shortfalls, and bonus payments for state performance for outreach and enrollment activities and for significant increases in Medicaid child enrollment.

The chapter highlights future issues facing CHIP, including interactions with state exchanges starting in the year 2014 and federal CHIP funding appropriated only through 2015.

That's all we have.

CHAIR ROWLAND: April, would you like to describe the MAC Stats.

MS. GRADY: Sure. As Christie described, we're going to have three chapters: Medicaid and CHIP in the context of the U.S. health care system, Medicaid, and CHIP. Those three chapters will be followed by what we're calling the gray sheets, although they're actually MAC Stats at this point, where we provide key facts and figures on the Medicaid program and, in particular, we provide state-level spending, enrollment, and eligibility information whenever it's available.

CHAIR ROWLAND: Thank you.

Comments from Commission members on these three chapters?

COMMISSIONER MOORE: I think the staff has just done a masterful job of describing the Medicaid and CHIP programs and how they are like many things that are going on in the larger health financing and delivery world, employer-sponsored coverage and Medicare in terms of cost and spending explosions, and new ways and approaches to efficiency and quality measurement and quality assurance, while also then pointing out the differences in Medicaid and CHIP in terms of the people that are served, the vulnerable population groups that are served, the poor, people with disabilities, the need for different kinds of services for some of these folks, long-term support services, assisting devices, and that sort of thing; and then the basic statistics, which is, I hope, going to become just a fabulously useful document for a lot of people in Washington and all over the country looking for basic information about the programs. So I think they've done just terrifically

well.

CHAIR ROWLAND: Great. Thank you.

COMMISSIONER GABOW: I think the decision to separate these into three chapters really made clarity about sort of the overview of where both these programs fit into the American health care system and what a support role Medicaid plays to both Medicare and employer-sponsored. Then having each of them separate gave us a chance to delve into each one in some more detail. And I love the MAC Stats. I really think that for people who don't have a ton of time and need a fact or a statistic, having everything gathered together at a state level I think will be an invaluable resource for all of us to make better informed policy decisions. So thank you for that effort.

CHAIR ROWLAND: Certainly to have 19 tables that all provide state-by-state data is really incredibly important, and I think where you also provide the total, it allows for some interstate comparisons, which obviously will be big pieces of our work to come.

COMMISSIONER COHEN: I also think the chapters are coming together incredibly well. The MAC Stats and the section with all of the detail I think just highlights the complexity of the program and how observations about the program from a national perspective can only take you so far. So I think it adds so much kind of richness to the description to be able to then break it out state by state and see how much variation it is.

I also think a lot of the charts highlight what we'll talk about later, is just sort of some of the data challenges in doing some of this analysis. We kind of like put it out there first and talk about it later, but the very fact that you need -- like there's so many footnotes to describe variation among states, and, you know, we even know that with the available information that we have now, we're

not able to capture the difference between, say, like, you know, a dental benefit in one place and a dental benefit in another place and they're not the same thing. I feel like it lays out the information first and leads us to really think about what we need to do about definitions and data to have a more holistic analysis for going forward.

CHAIR ROWLAND: Certainly in that listing of the benefits that are mandatory and optional and each state's choices with regard to them, checking the box is helpful to know that, as Burt will point out over and over to us, they offer dental services, but the scope of those services and the availability is very, very limited. So it helps us to know where we want to drill down underneath that box and find out what's really going on and maybe points out as we go forward the need to do some additional site visits and more in-depth profiling of one or two states.

COMMISSIONER RILEY: I would only add maybe those who open the first chapter and say, "This looks a little academic, let's move to the charts," and I think they would do that at their peril. I think what the Commission has done -- and the staff has done a magnificent job -- is to frame Medicaid within a costly, inefficient, complicated health care system that right now costs us too much and doesn't get us the health outcomes that we ought to have, and health status. So the frame I think is terribly important, and I think for the public to understand, not only have we been here at this meeting correcting footnotes and incorrect references, but there have been 17 of us sending track changes in to the staff and several iterations and several phone calls. That's an enormous amount of work in a very short time, and I think the depth of review by this Commission and the responsiveness of the staff has been incredible.

CHAIR ROWLAND: In a very short time frame.

COMMISSIONER CHAMBERS: I think I am going to be a broken record echoing what

other folks have said about this report and really what a great job the staff have done.

What I particularly like is, you know, this is really reflecting on all the chapters of the report that we're going to discuss as we go along, but really I see us as sort of the eye of a political and financial storm in which Medicaid and CHIP are a part of discussions here in D.C. and across the country.

I really appreciate that, as we've approached this, rather than rushing to some quick recommendations or sort of knee-jerk responses to what's going on, it takes a more practical approach of just laying out the context and what's going on.

I'll put in an unsolicited plug for Judy Moore who was a co-author of the book "Medicaid Politics and Policy" that I had a chance actually to look over this past week. And when I looked back to similar crises in the Medicaid program in the past, in the '80s and the '90s, actually you could re-read those chapters and take the dates out, and we're sort of facing the same challenges. Medicaid always survived, but in many ways you think, why did it survive? Is it because the economy improved and people sort of said, oh, we don't need to fix these things, we'll just keep going as we're going? I think it dictates that, you know, we really need to find some real long-term solutions to the structure and financing of these programs, and I think this is really -- the most appropriate approach is the way it has been done, so I really compliment staff in putting this together.

VICE CHAIR SUNDWALL: We are proud of what we've done to date, no doubt about it. But what pleases me is that this is really totally nonpartisan. This isn't a policy piece. It's an information document. I wish, as someone responsible to run the Medicaid program in Utah six years ago, I had read this and understood what I was getting into.

[Laughter.]

VICE CHAIR SUNDWALL: Because the complexity and the costs are just challenging for every place in the nation, certainly states and nationally.

So, thus far, I think that we have -- we will be making a statement that this is a very complicated, costly program that merits our attention. The only thing I would say is I'm not certain that we are as concerned about Medicaid as a program as we are about the people it serves, and we really are kind of patient focused, service oriented, and if there is a better way to do things, we welcome that. But we won't know what a better way is until we go through the work that we've embarked on here to get better information and analyze. And staff has done a terrific job of that.

So I'm confident that this will be a nonpartisan, useful report for people in the states and the federal level on both sides of the aisle. We met this morning with the Finance staff, Democrat and Republican, and I was certainly heartened by their interest in what we're doing and the fact that they want it to be data driven. They're hungry for information as they embark on consideration of different policies, some of which might be disconcerting. Whether it be doing away with the maintenance-of-efforts requirements or looking at caps or what have you, this will inform their decisions. And I'm hopeful that they will utilize this and that it will become a real reliable resource for them over time.

CHAIR ROWLAND: And is the Commission comfortable -- I mean, the balance we had here was the recognition that there is an existing set of programs, Medicaid and CHIP, serving a large number of people. There's changes envisioned in the health reform law to these programs. But what we've tried to do, I think, is to really look at the programs as they are today as the foundation for where we move forward in the future. But is everyone comfortable with that

balance?

COMMISSIONER ROSENBAUM: I think the staff have done a tremendous job of balancing the two, understanding that Medicaid is evolving, that the health care system is evolving, that essentially the best thing the Commission can do is to capture the program at this point in its evolution and report on it. And I think that it's definitely not about Medicaid under the Affordable Care Act. This is a report about Medicaid, and certainly issues related to the Affordable Care Act become relevant. But in this case, it's really Medicaid that has the dominant role, which is as it should be.

CHAIR ROWLAND: And having a Chapter 3 on CHIP helps us to not forget that while it's a smaller piece, it's half of our name and part of our responsibility. And I think the CHIP piece particularly is nice because it does set out how that program differs from Medicaid, how it's similar, and I think we need to look as we go through some of the other issues, like access and ultimately payment, to make sure that we're also taking into account the differences in how CHIP operates versus how Medicaid operates.

Are there other comments?

[No response.]

CHAIR ROWLAND: The first three chapters are ones in which we really are providing a foundation for where we'll go in the future. As we look at these chapters, are there areas that you think we don't have time or ability to address immediately but that are flags we should put out for delving in the future a little more in depth?

COMMISSIONER EDELSTEIN: One that was mentioned earlier was a focus on ER use, emergency room and emergency department use, that is probably worth taking a closer look at to

see whether there are some potential efficiencies to be had there.

CHAIR ROWLAND: Okay.

COMMISSIONER GABOW: I think as we look at the populations that are covered and the coverage, for example, as we've discussed Medicaid taking care of patients with behavioral health needs, and Medicaid and its EPSDT and CHIPRA, the CHIP with the dental benefit, point out sort of that this program, while in pieces, sometimes really tries to care for the totality of the patient. And I think one of the challenges that we should look at as we go forward is while we have these pieces, they're often separate, in separate delivery systems, and how do we pull these together, because they're all in -- the teeth, the brain, and the body are all together. It would be good if we could think about ways to take care of the whole patient in a coordinated manner. I think that's one thing we should look at.

And sort of related to that -- and we've talked about this, too -- is managed care. While some people may think that's not a good thing, I think if you manage care, which is really what the word says, it is good for the patient and I do believe would save costs. So I think those are two areas, the sort of linking of the behavioral, physical, and oral health in a more integrated manner and looking at managed care perhaps as a modality to achieve that, but even separately looking at managed care as both a delivery and a payment model and what is its efficacy in Medicare.

CHAIR ROWLAND: Okay.

COMMISSIONER ROSENBAUM: I would just like to expand a little bit on Patty's point because I think it's exactly correct. One of the most important questions that I think we're going to have to ask ourselves as we take a look at these issues in managed care is the degree to which our thinking about managed care -- and I'm sort of using the word in the vernacular now -- has

expanded since the original Medicaid managed care amendments of '97 were drafted. That is to say, those amendments were, of course, an evolution from legislation in the '80s, and I've been struck in thinking about the relationship between Medicaid and other forms of insurance, specifically the issue of the interaction with people who are in exchanges, how important it will be to think about not how new delivery systems have evolved, how other sources of insurance coverage have evolved, how new theories about how you would structure managed care, whether for people who have routine needs or people with more advanced needs -- all of that I think needs to be brought back to the legislative authority that exists today so that when we look, we're looking not only to how managed care can be used, but whether the provisions that are in the statute today are provisions that can carry this evolution, or whether states are still having to rely on special demonstration authority, which I think is a problem. So it's not just populations, but it's also delivery options under current law.

CHAIR ROWLAND: Okay. As a future issue.

COMMISSIONER ROSENBAUM: Yes, a future issue.

CHAIR ROWLAND: Other discussion?

COMMISSIONER CARTE: Just following Patty's thought about linking teeth and brain to the rest of the body, I would just point out that when CHIP was reauthorized, one of the things that happened there was that there was a strengthening of both dental and mental health coverage, at least for the separate CHIPs that were more commercially modeled. So as CHIP families look at making choices in the future through an exchange, that will be one of their considerations.

COMMISSIONER RILEY: I think as we talk through the access piece, particularly around appropriate access, which I think is -- it ought to be one word because access to things that don't

work isn't really value added. We need a better literature base and evidence base about what is appropriate care and what works and what doesn't, particularly around issues of disability where the cost drivers are. We know so little about what works and what doesn't in physical and behavioral health, and I think that's a critical component as we address appropriate access.

CHAIR ROWLAND: Which we can get into a broader discussion when we get to the access chapter.

Other comments to the staff on revisions to this set of things? Other than that the tables need to be bigger so I can read them.

[Laughter.]

CHAIR ROWLAND: I think that clearly our comments have all been very enthusiastic because I think this is a really nice foundation to set out how the two programs work. I think it does keep CHIP in the spotlight by having that a separate section so that we don't just occasionally mention CHIP when we talk about Medicaid. But I think we also ought to recognize that as we get into this report, we're leaving large pieces of the Medicaid program outside of the framework that we're starting to talk about in terms of payment and access. So at some point we will need to engage, as the statute gave us such a broad set of responsibilities, in more of the long-term care, dual-eligible issues, and that right now we're focused on the ones that started in our CHIPRA authorize. So I think this sets the tone for the scope of the programs, but it really is a starting point.

So I know you'll be back giving us more foundation on other pieces, but thank you right now.

COMMISSIONER HENNING: Just a quick question, Lu. As part of this report, were

we going to have the little glossary of terms thing?

EXECUTIVE DIRECTOR ZAWISTOWICH: We are exploring whether or not we can do that, so we're looking into it.

COMMISSIONER HENNING: Okay.

CHAIR ROWLAND: Ideally, I think that was a great suggestion, that acronyms abound in this world and that a glossary of terms would be a useful piece. If we don't get it done in the March report, maybe we can keep pressure on the staff to have it in the June report, which is coming very soon.

COMMISSIONER SMITH: I have a comment on that. I think the staff did a really good job following through with that within the report itself. I think they were very cognizant of making sure there was always initially a definition of an acronym, and that was very helpful to me. I found it very readable as a lay person.

CHAIR ROWLAND: That's great.

We're going to turn now to Session 2 where one of our charges -- the first part of our name is Medicaid and CHIP, and we have an overview section in the first three chapters that covers those two words broadly, and now we go to the other half of our name, the Payment and Access half, and so we're going to start this discussion with looking at the payment chapter and the framework that we're trying to set up for payment.

Patti and Jim, why don't you set out sort of the broad area that this chapter covers and what we were attempting to do. ###

EXAMINING MEDICAID PAYMENT POLICY

MR. TEISL: Okay. Thank you.

As Diane just mentioned, what we're going to do is give a very broad overview of what's in the chapter, and then we really look forward to your ongoing comments regarding the chapter and are looking forward to where we go from here.

As you all know, MACPAC is charged with examining Medicaid payment policies, the methods, and their impact on access, efficiency, and the quality of health care.

Some quick highlights of the payment chapter. We cover an overview of Medicaid as a health care payer. We then move into the legislative and regulatory requirements, specifically around hospital payment and physician payment, and we get into some specifics regarding the variation across states in paying for those particular services. Then we talk a little bit about our approach and our plans looking forward around Medicaid payment analysis.

Within the first section, we're going to talk a little bit about the fact that Medicaid is a significant payer in the U.S. health care system, and at the same time it's a very unique health care payer. You can see some stats that we have up here. Medicaid accounted for 15 percent of total health care spending in 2008.

In addition, Medicaid is a particularly dominant payer for certain services. Examples that are familiar to all of you include obstetrics, pediatrics, behavioral health, long-term care, and others.

In addition, it's also a particularly dominant payer for particular types of providers, including, for example, safety net providers, public hospitals, community health centers.

Medicaid serves a diverse patient population, and it provides services that other payers do not necessarily provide. For example, Medicaid makes payment for long-term care services and supports, transportation services, certain therapies, and in these respects Medicaid can be somewhat unique.

There are some other things that are unique for Medicaid as a payer. The federal-state financing partnership requires states to contribute funding. States have to balance their budgets. In addition, costs in Medicaid tend to increase when revenues for the states tend to decrease, commonly referred to as "the countercyclical nature" of the Medicaid program.

One other that I'd add --

CHAIR ROWLAND: A word we intend to use.

[Laughter.]

MR. TEISL: Exactly. I made sure to get it in.

CHAIR ROWLAND: We'll put it in the glossary, too.

MR. TEISL: Definitely. One other that I'd add is cost sharing for Medicaid services. States are limited in their ability to apply cost sharing or to use cost sharing as a utilization control, largely because of the nature of the population that it serves.

In the chapter, we go through an overview of the legislative history of Medicaid payments, specifically for hospitals and physicians. Here we've boiled it down to one particular statute known as 1902(a)(30)(A). A couple things that I'll point that are in this sort of foundational Medicaid payment statute. It requires states to provide such methods and procedures relating to the utilization of and payment for services as may be necessary to safeguard against unnecessary utilization, assure that payments are consistent with efficiency, economy, and quality, and also that payments are sufficient to enlist enough providers, at least to the extent that people have access equal to the general population. This, as you all know, creates a little bit of tension between making payments sufficient or to be consistent with economy and efficiency, but also to provide quality and sufficient access to care.

Under these sort of broad federal requirements, there's quite a lot of variation at the individual state level in the way that Medicaid pays for services. We list some examples up here, and I would just add, even within these examples, 32 use DRGs, 9 use per diem, 5 use costs or charges for inpatient services, there are a lot of nuances even within these bullets. So while it seems sort of simple to group them into these categories, the way that states really pay providers is very nuanced, very complicated, and requires us to take a very state-specific view of the way payments apply.

MS. BARNETT: So as we are looking forward -- and we look forward to your comments on our future work in this area -- we will be delving deeper into the variation that Jim spoke about and getting a little bit more detailed in terms of how states specifically pay a wide range of providers.

While we started in this chapter and began our discussion with fee-for-service hospital and physician, we recognized that issues and challenges with implementing value-based purchasing affect all providers and affect even all-payers. So as we move forward, we will look at payment issues for other providers, in particular, long-term care providers, looking at payment policy, managed care payment policies, and payment for other providers.

As we move forward in this, our first task is going to begin to build a detailed baseline of how states pay all providers, and from that baseline we can begin to tackle many payment policy questions that the Commission would like to address.

So we look forward to your feedback on our draft chapter and on our approach looking forward.

CHAIR ROWLAND: Let me start by asking you if we are going to establish a baseline to understand individual state policies, what you think that will entail. I don't think there's a ready

place you can go and get all this information now.

MS. BARNETT: There is not, and this is going to be a great undertaking. There is not a single depository of all this information. A lot of these details are buried in state plans that are not readily available. So we are going to -- it's going to be some hard work, and we're going to have to work really closely with the states, and we look forward to doing that to really understand. As Jim sort of pointed out, the devil is sort of in the details of how states pay providers. So we really hope to get at that because without that I think we can't really begin to tackle a lot of the questions that I know all of you would like to get to.

CHAIR ROWLAND: Lots of different providers.

MS. BARNETT: Yes, wide range of providers.

CHAIR ROWLAND: So we started with hospital and physician, but know that there are many, many other provider types that are in the mix.

Comments from Commission members?

COMMISSIONER MOORE: I'm just curious if you've given any thought as to how you're going to go about the next steps. Will you pick ten states and look at lots of their systems? Or will you pick several kinds of reimbursement and try to go after all states? Or are we still kind of in the developmental stage at this point?

MR. TEISL: I would say we're very much in the developmental stage, and actually, we'd really appreciate your input into what you think is the best way to go about it. As Diane just mentioned and we mentioned in the presentation, there's a very wide range of providers. Obviously, there's 50-plus programs. We want to be comprehensive, but we also need to be very deliberate in the way that we approach it. So we'd really appreciate your thoughts on it.

COMMISSIONER RILEY: The secondary sort of nuance to this variation theme is that we also have to build in the understanding that states are so different. Their cost basis is different. Their service delivery systems are different. Their practice patterns are different. And maybe if we do do a sample of states we could create some kind of a matrix that identifies high-cost states, states with high penetration of safety net providers, and the like, because Maine looks very different from Colorado, and it seems to me that's a really important piece to understand. The reason some states pay the way they do is because their systems look fundamentally different or they're more costly.

CHAIR ROWLAND: And I'm assuming that you can't get the depth of information you need from state plan language or anything else, that this is really going to require either direct contact with the states, which may go to your point of how many states you actually do. Do you do a sample of states that have different methods so that you have illustrative examples versus collecting it nationally?

COMMISSIONER ROSENBAUM: Yeah, along those lines, I think one of the most important things we have to figure out is how to capture what we could think of as differences in the extent to which states allow efficiency substitution, and by that I mean states that have very broadly conceived scope-of-practice acts that allow considerable substitution of one class of health professionals for another for a significant amount of care, and beyond that, the extent to which the Medicaid agency captures that substitution. It doesn't follow like night and day that just because a state's scope-of-practice act is quite broad that the Medicaid agency in that state has captured -- has a payment policy that makes full use of a broad scope-of-practice act. So you really have to look at two things.

But I think one of the most important issues we might be able to shed some light on is the extent to which payment is making the best use of the efficiency opportunities that underlying state law related to health care practice allows. So, you know, if you have a state -- I think a place like Colorado -- the Western states are quite different in this respect -- that have a very broad approach to scope of practice and we find that Medicaid agencies, in fact, are or are not emphasizing broad scope of practice in their own payment policies, that would be terribly important. And states with much narrower scope-of-practice acts, the Medicaid agency may be hampered in ways that other state agencies would not be.

CHAIR ROWLAND: That's a good point.

COMMISSIONER RILEY: Can I make a friendly amendment? Because I think in terms of scope of practice, there's also the issue of telemedicine and telehealth.

COMMISSIONER ROSENBAUM: Yes.

COMMISSIONER RILEY: On the one hand, in rural areas it can really do a great deal to increase access at lower cost. The flip side is some worry that it would lead to overutilization. And I think it's an area we don't know much about, but it has great promise and is so emerging that we ought to take a look.

COMMISSIONER ROSENBAUM: I would think we'd want to define what we mean by a broadened scope of practice, both substitution of personnel, substitution of settings, use of technology. So there's a range of issues that we might sort of delve into here.

CHAIR ROWLAND: I see Denise getting ready to say something.

COMMISSIONER HENNING: I'm just thinking it's great that Sara's on the panel to speak up for me every once in a while.

[Laughter.]

COMMISSIONER HENNING: Because sometimes I feel like I'm beating my head, you know, against the wall. And I think that it's really important, especially as a certified nurse midwife -- I'm going to put a plug in for my profession -- that we look at outcomes and the fact that advanced registered nurse practitioners and certified nurse midwives, certified nurse anesthetists, physician assistants, and that kind of thing. When you look at the data that has been collected on them, they provide equivalent quality care, and in some cases even better outcomes. In particular, nurse midwives have lower pre-term birth rates, and it's not just because we're taking care of low-risk women because we're not. That's a real misnomer. We are collaboratively working with physicians to take care of a fairly high-risk population in many cases because we're working in federally qualified health centers and we're working with low-income either uninsured or Medicaid populations. But we still have lower pre-term birth rates. We have higher birth weights on average. And our women have quality care that they're generally pretty happy with and a much lower cesarean section rates.

So it can be done, and, granted, the cesarean section rate may not save the clinic that's employing a nurse midwife any money at all. In fact, it may be making them lose money because you get paid more for a C-section than you do a vaginal delivery. But it's saving our whole health care system a lot of money, and it's also saving that woman from having a scar that could potentially cause her problems later on with her next delivery.

CHAIR ROWLAND: I have asked that the heat be turned up in here. It's freezing.

[Laughter.]

COMMISSIONER GABOW: I think as we look at these different payment

methodologies and different payment models, I think a key question to explore is how have these payment models been utilized as levers to actually improve the care or improve the delivery model from being a fragmented one to an integrated one or to use a broader scope of care. So I think because we ultimately want to provide some policy recommendations, understanding how payment models are a lever for creating a better Medicaid system I think would be very important, not just to create a topography of all the payment models, but how they're used as a lever.

COMMISSIONER COHEN: I was just going to say, first of all, you know, I think it's -- we're obviously the Payment and Access Commission, and so it's very important that we are diving into payment, and I'm very excited about it. Obviously, like elsewhere in health care there is so much time and attention and analysis being spent on what is the best way to pay for different kinds of services, and we can't just adopt that work for Medicaid. It's a different population, a different set of services, all of those things, but it's so important that that kind of work is being done. And I think one thing that we have heard over the course of our prior meetings is that it's a little bit of an underdeveloped kind of field, both within -- it's very resource intensive -- both within CMS and at the state level.

So this chapter, I think, more than many, and this sort of endeavor maybe more than some others, I feel like our audience may be states as much as Congress in that to the extent that we can really help to build a base of sort of information, a basis for evaluating payment systems, and those sorts of things, I think we can really -- you know, we can really sort of move the field along a little bit in Medicaid.

I do, of course, want to point out that, depending on one's personality, it's easy to get very wrapped up in technicalities of, you know, incentives and how a payment system might incentivize

this thing or that thing. I think the chapter does it well. If your payment level is way off, it really doesn't matter how great the technical sort of formula or methodology for developing it is. Your relative values sort of don't mean very much if the basic level is really off. So we, of course, have to keep that in mind as well.

CHAIR ROWLAND: In terms of going forward, one of the issues that you flagged in the report is the potential impact of the required increase in primary care fees and consider how these payment increases would be passed on or dealt with in the Medicaid managed care plans. Can you talk a little bit more about where you think we ought to be going, what you're laying the groundwork for being able to assess the impact of that and some of the new data that we've collected?

MS. BARNETT: We are just starting our work in this area, and I think the first thing that we are planning to do is to look closely at the codes that are affected by the increase and trying to get a sense of the magnitude of impact across different states. So I think that's our first step.

Then I think what we hope to do is work with -- or learn from CMS what they are doing in this area, especially in terms of managed care, and hopefully get some great insights from Richard and Donna on this, too.

But those are, I think, our first initial steps. I don't know if -- do you have any?

MR. TEISL: No, only to add that, you know, within this chapter we include a little bit of information regarding the variation in physician payments, and that's largely to demonstrate that the impact is going to vary dramatically depending on the state that it's applied to.

CHAIR ROWLAND: And that information was commissioned--

MR. TEISL: Actually, we commissioned the work through the Urban Institute, and it's what we actually asked them to look at. It's similar to work that they've done previously to index

physician payments across different states. We asked them to specifically look at the fee levels for office visit codes as a beginning step towards an investigation of this impact.

CHAIR ROWLAND: And comparison to Medicare or --

MR. TEISL: We didn't include it -- we did not include it in this chapter this time. What we do have is a comparison of individual states to the national index, and, again, it's largely at this point to demonstrate the variation across states.

CHAIR ROWLAND: Okay. Other questions?

VICE CHAIR SUNDWALL: Just one comment. I really appreciate your work on this. I found it very informative for myself.

There was authorized -- or I don't know if it was part of ACA or before, but the new Center for Innovations at CMS. Are you following those, whatever they're funding, when it relates to payment reform and how we might take advantage of what they're investing in.

MS. BARNETT: We plan to work with them. We are definitely following and tracking the various demonstrations that were included in ACA, and the Center for Medicare & Medicaid Innovation we'll be looking at. So we intend to be working with them. I know that there is a global payment demonstration for safety net hospitals. I know that is going to be coming down the pike pretty quickly. So we plan to be following that.

CHAIR ROWLAND: Since this doesn't specifically address managed care, which we intend to take up as a topic more related to our June report, could you talk a little bit about what some of the issues are in looking at payment policy within managed care plans and how we'll go about looking at that for the next report?

MR. TEISL: Well, what we did with this chapter is, as you mentioned, begin to introduce

the concept of managed care payment, the differences between managed care payment and the more traditional fee-for-service payment. One thing that stands out or jumps out right away is the requirement for managed care premiums to be actuarially sound.

Some of the things we want to do going forward, the one that comes right to mind is -- we talked a little bit about the primary care bump under the PPACA. We want to look at how those payments will be passed on from the state to the managed care organizations, and then also look at the next step, which is how the managed care organizations pass those payments on to the providers. It's one of the earlier areas that we want to get.

MS. BARNETT: And I think broadly, just really in future work examining just the rate-setting process that states go through, the use of risk adjustment. So I think those will be the topics that we will start to dig into in future reports.

COMMISSIONER CHAMBERS: Also, when you're looking at managed care payments from the state to the plan and the plan to actual providers, is taken into consideration P4P, you know, programs that plans have --

CHAIR ROWLAND: That's pay for performance for those who need a glossary or want a glossary.

[Laughter.]

COMMISSIONER CHAMBERS: -- that sometimes get left out of the equation. I mean, oftentimes in our delivery networks the physicians tend to focus on, you know, the payments, either fee-for-service payments from the plan or even in capitation that's put together primarily for primary care physicians, and they tend to leave that out of the equation. But it certainly is a big piece of payment and getting access and quality and all of the things that we're really concerned about, both

from a fee-for-service and from a managed care perspective.

COMMISSIONER ROSENBAUM: I just want to bring attention to an issue that I think we should be mindful of as you're constructing the managed care portion of our work. It's something that, you know, I have found over the years bedeviled me and my thinking about managed care, which I actually have always seen as a great advance in Medicaid because of its access-enhancing potential.

But one of the problems in comparing states is going to be the extent to which, because of the structure of state contracts, there's more or less extra contractual payment going on. So no two states are the same, not only in how they structure their agreements, but in what they leave out of their agreements, down to certain procedure codes, down to certain treatment settings, a lot of other variability that affects total payment for the managed care population that may be significantly more than what is paid to the managed care entity. Of course, there are many times when a managed care entity may be expected to actually manage care even when payments are direct from the Medicaid agency to outside providers.

But I think we're going to have to have a way of showing people that managed care is a very important advance, and depending on the state for different kinds of populations and care needs, but that there are common procedures and services that even for the managed care population are often not put into a contract. I think this is a little understood part of the dynamic, and some of the most important things that Medicaid does, going back to our Chapter 1, has to do with those activities that don't lend themselves easily to, you know, what you could think of as a plain vanilla managed care contract. You've got to structure it differently.

So it is, I think, a really important nuance in the whole arrangement that we need to be sure

policymakers understand.

CHAIR ROWLAND: Okay. Other comments? Other provider groups that we should put on our future agenda?

I'm waiting, Burt.

[Laughter.]

COMMISSIONER EDELSTEIN: It may go without saying.

[Laughter.]

CHAIR ROWLAND: I do think that while we start here with physician payment, the issues that we're all concerned about include the broad array of primary care providers, and while the statute in the health reform law specified doctors, we know that scope of practice is important in broadening the base, and we know that dental care is included in the care there.

So as we look at our future agenda and when we start gathering information, it may be prudent to not -- if we're going to into a state, to not just gather information about one particular provider type, but to broaden our definition of what we're getting information on, because I think our ultimate goal will be to look at some of the trade-offs about which provider type is there. And as we get into what we will discuss in the access chapter is availability of providers and level of providers doing some of the treatment, we'll want to know how the payment policies may impact the availability of those providers and their willingness to participate.

COMMISSIONER MARTINEZ ROGERS: I think that's a really good point, Diane, in particular because -- and I think Denise would probably agreed -- in the rural communities we frequently find that it's the nurse practitioners or the PAs that are providing the service of care. Mostly the nurse practitioners because a PA, I believe, has to work directly with a physician, and a

nurse practitioner doesn't. So what we're finding in Texas in particular is in our real remote rural areas, we're finding more pediatric nurse practitioners and psychiatric mental health nurse practitioners because there are no psychiatrists or pediatricians. So I think it's very important in terms of how they get reimbursed that they be kept on -- when we address things, and we've said this before, that we don't look just at physicians but at other health professionals.

Thank you.

CHAIR ROWLAND: I think as we did our discussion of providers, we also know that while there's a primary care emphasis that has been introduced into the payment issue for Medicaid from the health reform law, there's also gaps in access, especially to specialty care and to some of the behavioral health services, and that we can't leave that out of the equation either.

COMMISSIONER EDELSTEIN: Your comment, Diane, reflects the fact that we really can't separate payment from access, although for a clearer understanding of this initial work of the Commission, it's important to have a chapter on payment and a payment on access. But the --

CHAIR ROWLAND: Not a payment on access. A chapter on access.

[Laughter.]

COMMISSIONER EDELSTEIN: I'm sorry. A chapter. But the next chapter --

CHAIR ROWLAND: We want a downpayment on -- maybe it's a downpayment on access.

COMMISSIONER EDELSTEIN: The next chapter, though, does feature a schema in which the issues around the providers are well articulated, and I think that the kinds of things we've been talking about here with regard to payment are re-emphasized and expanded in that schema.

CHAIR ROWLAND: Great.

COMMISSIONER MOORE: That was an awfully good segue for us to move on, but I --

[Laughter.]

COMMISSIONER MOORE: But I thought I would say to Jim and Patti and Lu and all the other staff who worked on this chapter, I think it's a wonderful cataloging of information on Medicaid payment, and I don't think such a document or this information has ever been put together in one place before. So I think it will make a real contribution just as an initial information and education piece.

CHAIR ROWLAND: I particularly, as you know, really like the fact that we started in 1965 and gone through the major changes in legislation that affect provider payment, and really I think the other point of this chapter, which gets into the data issues as well, is how much provider payment is driven as a state issue and has less federal data on it and less federal oversight and less federal standards than we see when we deal with issues around eligibility or even benefits.

So I think that the segue that Burt tried to create that Judy interrupted a little is a good one, and we really do need to turn to the access chapter that ties directly back to the payment chapter. So we thank Patti and Jim, and we'll switch characters.

CHAIR ROWLAND: Thank you, David. ###

ASSESSING ACCESS TO CARE IN MEDICAID AND CHIP

MS. SIMON: Hi, Jen and I are here to talk to you about Chapter 4 of the March Report, and before I start I just want to acknowledge Molly McGinn-Shapiro who joined MACPAC in mid-January. I think you met her at the last meeting. But she kind of joined our access team and we really couldn't have gotten this far without her. So, I just wanted to acknowledge her.

So, in Chapter 4 of the March Report, we lay out the Commission's Approach for

Examining Access to Care. At the December meeting there was a lot of discussion on the importance of coming up with a systematic and analytic framework or approach that would allow us to best meet our charge. So, from the discussion that we had at the December meeting, we realized that our first step was really to, you know, take a step back and come up with a working definition before moving forward.

So, the structure that Jen and I are going to present today is a way of proceeding with our work on access.

So, as Diane mentioned, as is reflective in MACPAC's name, reviewing issues related to access is one of the primary charges of the Commission and this framework is a work in progress and was designed to be responsive to considerations that are unique to both MACPAC and its charge.

So, efforts to conceptualize access to health services have a long history and this history was really instrumental in forming our approach. To guide the development of the framework, we began with a review of the literature on the topic and we found that definitions have evolved over the past 30 years, they're multidimensional, and over time have incorporated a range of aspects such as the fit between providers and patients, and the concept that insurance coverage alone does not guarantee access if other essential ingredients are missing.

The IOM in the '90s put an emphasis on appropriate use of services to drive outcomes and more recently there has been an increased emphasis on looking more broadly at quality in the performance of the healthcare system. So, this historical work is reflected in our framework.

But we also realize that to be effective for MACPAC, the framework must consider issues that stem from the specific characteristics of the Medicaid and CHIP populations, so it also must

take into account first the federal-state relationship, which is very complex and complicated, as well as variability among states, which we discussed in the last session with regard to payment as well as eligibility and other program features.

So, I also want to stress, the framework was designed to be an evolving one and to allow us for flexibility and how it's operationalized, we intend for it to evolve as the Commission's priorities change, as new questions are raised and new issues emerge.

So, Jen is now going to give a brief overview of the framework and there you go.

MS. TRACEY: Thanks, Lois. This slide actually shows the Commission's proposed framework for examining access to care for Medicaid and CHIP enrollees, and as you can see, there are three main components to the framework: enrollees, availability, and utilization. And Medicaid and CHIP enrollees are really central to the framework, since obviously they're the reason that we're evaluating access.

CHAIR ROWLAND: Pull your mic over.

MS. TRACEY: Thank you. Is that better? Okay.

Medicaid and CHIP enrollees have unique characteristics from the general population. They tend to have lower incomes, less assets, they also have more complex health conditions. In addition, there's quite a bit of variation among states in the eligibility requirements that allow individuals to enroll in these programs.

The second component of our framework focuses on availability and this focuses on availability of providers to serve these individuals. So, the first component focuses on provider supply, so are there an adequate number of providers in a given geographic area.

The second component looks at whether these providers are actually participating in the

Medicaid and CHIP programs. The third component of the framework focuses on utilization, so how are these individuals utilizing services? Services used focuses on issues of do they have a usual source of care, are they getting checkups, physical examinations throughout the year. Affordability of services also becomes an important factor.

Some states have cost sharing requirements for Medicaid and CHIP services and they also may cover limited benefits which may impact access to care for these individuals.

And finally, system navigation and patient experiences are also an important part of utilization, and this really encompasses things such as office hours and appointment wait times, cultural competency fits in to this, as well as just patients' perceptions of overall satisfaction with their health status and their relationships with providers.

And finally, the bottom part of the framework focuses on evaluating access. So, now that we have a framework in place to work with initially, what are the types of things that we're going to look at to see if access is adequate? Appropriateness of services and settings is one of the key elements of this. So, are the right services being delivered in the right settings at the right time? Also, are services efficient, economical, and are they of high quality? And one of the most important outcomes, are we seeing positive health outcomes as a result of access to care?

This next slide, we just wanted to show you some of the potential measures that the Commission will be looking at further to assess access. We have more of these in the report where we've included a larger sample and these will be evolving, but this just kind of gives you a flavor of the types of measures that are available for each one of these components of the framework that we'll be delving into more in depth in the future.

MS. SIMON: So, the framework Jen described, as I said before, is just the first step in the

Commission's work towards fulfilling its charge. Our next step will be to identify a set of core measures just as the ones that Jen described, and using these measures we want to first examine where access levels exist today. And then we intend to be able to track trends and monitor the measures over time.

We also intend to compare Medicaid and CHIP to the privately ensured as well as the uninsured as well as to look deeper into differences among different subpopulations, and our analyses will take into account differences in needs and use that may exist because of health status and socioeconomic status.

Also we realize, and this is part of our charge, that just examining access isn't enough. We will assess how changes in federal and state policies can alter the availability and utilization, and as well as negatively or positively affect access. And going forward we want to be able to provide guidance and strategies that link actionable solutions or policies to access.

We also want to learn from states. We want to work with them in identifying what works and once we identify what works, share them with other states.

And with more than half of the Medicaid and CHIP populations in managed care, that has kept coming up today, it seems extremely important to examine access policies in the area of managed care, comparing the fee-for-service and looking among different states as well as different managed care delivery systems.

And lastly, this framework will serve as the basis for the creation of the Early Warning System, which is another one of MACPAC's charges.

So, that's our "looking forward" section, and we look forward to your reaction and guidance.

CHAIR ROWLAND: Thank you. Patti, Denise, Burt, Trish?

COMMISSIONER GABOW: I think this access chapter is critically important because you really can't have quality if you don't have the first step, which is access.

I would remind us, particularly in the era of changing communication, that we not think about access in the narrow confines of face-to-face visits with any provider, and I'll just give you two examples in our own system. One is, we have a nurse advice line that gets 100,000 calls a year. Half the users are Medicaid, and we even give out prescriptions on that line. Now, when you think about who is a Medicaid patient, where transportation is an issue, geography may be an issue, something that is as simple as a telephone, I mean, we tend to think of telemedicine as something sophisticated, but the telephone is good.

And I think another example which sort of points out that we shouldn't think about necessarily face-to-face visits is that you might think that this population wouldn't have access to some of the newer modalities like texting, et cetera, but we're doing a pilot with diabetics and we were floored to find out that 70 percent of our patients in this pilot actually had access to text messaging. They might not have land lines, but -- and so I think that thinking about that we shouldn't confine ourselves to, you know, where providers are or necessarily think about face-to-face, which wraps us back around to payment, because if you are in a fee-for-service model, many of these things would not be paid for and hence not used, even though they're lower cost, maybe better for the patient.

So, I just think we -- especially given, you know, what we've seen in the last couple weeks about the power of alternative communication, we should understand that it has power in things as simple as healthcare delivery as well.

COMMISSIONER HENNING: I'm not exactly sure what it was that sparked this idea in

my head, but there's a concept called group care, and in particular for pregnant women it's called Centering Pregnancy, but they also use this group care for diabetics and for other people with chronic health conditions.

And basically what happens is they bring a group of people together that have the same kind of health problem and the visit may be longer, but it has a lot more educational component and that kind of thing to it, and in the case of Centering Pregnancy, the visits are actually spaced out maybe a little bit more, farther apart, than what they normally would be under traditional prenatal care, but the visits are so intensive and so rich that what we find is that the outcomes are actually better, the pre-term birth rates are better and those kinds of things because the women are getting so much more education, plus, they form their own social support group, which is actually a really helpful thing for a pregnant woman, you know, to have that, you know, bonding with other pregnant women that are kind of at the same stage of pregnancy, because you kind of group them in with the same due date month.

And I'm thinking that in general, we need to start thinking about ways to provide healthcare that are different than what we've been doing, because isn't the definition of insanity to continue to do the same things and to expect a different result? You know? So, let's start thinking outside the box a little bit with our healthcare system and see if we can't provide better quality for less cost.

CHAIR ROWLAND: Burt.

COMMISSIONER EDELSTEIN: Well, picking up from Denise, one of the places that we can continue to look further in the future is around disease management and obtaining better health outcomes at lower costs. I know in the case of oral diseases, there certainly is tremendous opportunity to reduce the need and demand for reparative services and their high failure rate, at least

with regard to young children -- I should say recurrence rate rather than failure rate, especially with regard to young children who are served under the most expensive and most demanding of treatment, that is preschool age children who have their dental services in the operating room under general anesthesia, who account for a significantly disproportionately large portion of the Medicaid dental expenditures and real cost savings with better health outcomes could be obtained there.

But I did want to point out that we need to tie the payment and the access together and one way that we can do that is on the schema where we have the provider availability issues. Do you want to go back to that?

Under availability where we have the provider box, we currently have Provider Supply and Provider Participation, but by also adding their Provider Distribution and Provider Payment, we tie the issues of payment and service availability together. And I think this breakout between availability and utilization is really a critical one because there are those who believe strongly that the primary problem is on the availability side, and there are those who believe strongly that the primary problem is on the utilization side. And having them well balanced in this schema, I think, explains that it takes both sides to have successful care delivered that is then appropriate, efficient, economical, quality, and results in positive health outcomes.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I was -- I'll just say ditto to Burt. I think the key this morning -- it's not evaluating access, it is access, and I think it's really important that we've set this access chapter up in a context that recognizes that more is not always better, and that we've got to be sure that we don't just do more and more, that we do the right care at the right time, right place, right cost, so that that rightness factor also connects the payment to the access.

CHAIR ROWLAND: We'll go back to -- we have Norma, Sara and Burt or did you want to directly respond?

COMMISSIONER EDELSTEIN: Just a quick thing on this. I want to commend the staff in particular on this. I know the Commission was pretty critical of the first couple of drafts of this one and it evolved, and as you mentioned, it will continue to evolve. But I think this is a significant contribution because it really does take what is generally known about access and characteristics of healthcare and apply it most specifically to the populations covered by Medicaid and CHIP, and I think this will be one of the real contributions of the first release by the Commission.

CHAIR ROWLAND: Norma?

COMMISSIONER MARTINEZ ROGERS: I think that those are all very good points, but I also think that we do kind of have to think out of the box, and that is, when we talk about access and when to use it and utilization and cost, you're talking about -- and I mentioned this earlier about health literacy -- it is something that has -- there is some part of a component that needs to be about teaching people. When do you -- how do you access and when do you use it?

In our rural communities in Texas, and I don't want to just keep talking about Texas, but since I am from Texas and we have multiple problems there, and because we're so rural and so other states are also, but, you know, we use what we call the promotoras which are community health workers that live in the community, and California uses them quite a bit also. They have the largest, I think, group. And it's -- they're the ones that go to the patients or the clients and say, this is how you access, this is what you need to do, because any time you're talking about health literacy issues it becomes a problem in access and utilization.

CHAIR ROWLAND: Sara?

COMMISSIONER ROSENBAUM: Going back to Denise's example, I think one of the future ways that the Commission might be able to make some of the points that we are trying to make would be actually to take maternity care as an example, as a case study, and the reason I think maternity care is ideal is because as I just said Andy, this I remember from my former life that the literature on what can affect the outcome of a birth goes back probably a century.

We know a lot about organizing and delivering maternity care: how you should define it, what should be in it, how you might mix-in individual visits with group activities, services and supports through labor and delivery and the newborn period, and then, you know, transition to infant care. And no group of women, of course, is in greater need of these kinds of innovations than women who depend on Medicaid, and I think it would be very interesting to pull the literature together showing how far back it goes, what the principle payment issues are that arise in Medicaid, how many of those payment issues stem from limitations in the federal law itself that would prevent a state from introducing certain innovations, and how many of the innovations stem from choices that states make -- not always the state Medicaid program, I might add.

I mean, again, this goes into scope of practice, it goes to a lot of issues, but it seems to me if we could take a very well known, actually, you know, high cost service, especially when you add in the costs of things not turning out well, and demonstrate the extent to which, and we should make the point that we could have done this exercise with any insurer, okay, and we'd see the same kind of pattern, so this is not -- it's just that our charge is Medicaid -- but we could, you know, interestingly line -- we could line it up with Medicare for pregnant women too, but show that there is just this large gap, that it's not just about the amount of money you're paying, it's about how much

we're pulling payment toward what is known, in some cases has been known for decades about how to do a service right.

And I think that there may be other interventions, health interventions, that provide a powerful example, but I'm trying to think of ways that we can make this real for members of Congress and the public to show that Medicaid is sort of a reflection of a lot of choices that get made along the way that accumulatively produce a result that's not what anybody wanted, and so if we could pick, you know, a few of these principle kinds of interventions and work them up for Congress, I think it might help.

CHAIR ROWLAND: Since Medicaid picks up 41 percent of the live births, it would be an area where Medicaid has a substantial enough role, where looking at variations, looking at different practices, would give us a lot of information that is very central to the Medicaid program and ultimately to CHIP as well.

COMMISSIONER CARTE: Yeah, along those lines here I would be interested to see if there's -- if we have any information about payment mechanisms that incentivize physicians and mid-levels to take -- to assure that the births are taken to term and I've read a lot of things where that's not happening even though that's a clearly desirable outcome and influences the health of the baby and mother.

CHAIR ROWLAND: Denise?

COMMISSIONER HENNING: There's kind of two answers to that. One is that there is right now a project that is sponsored by the March of Dimes that basically focuses on pre-term births, specifically, and especially elective C-sections and the scheduling of them, because the dates at which physicians were scheduling C-sections kept getting marched back and back and back, and

this is for people that really, you know, other than the fact that they had had a previous C-section, there was really no reason to be delivering them at 36 weeks, and so now the recommendation is that any elective C-section be scheduled at at least 39 weeks, and that doesn't mean if she has a medical problem or an issue that warrants earlier delivery that you don't do it then.

It's, you know, the routine person that has no other health issues that warrants earlier delivery should be taken to at least 39 weeks, and what that has done in the places where they've instituted those rules, is it has dropped NICU admissions significantly which saves hospitals money because they don't have to build these big old expensive NICU units. It saves, you know, Medicaid and other insurance companies a lot of money. So, you know, that project is ongoing but there's a lot of private physicians that don't like that because OB/GYNs, they have to be available when that person comes in in labor to do a C-section in the middle of the night. It sure is a lot easier to do it in a reasonable hour of the day, and it's, you know, it's a human thing.

But then the other issue is that there's a Transforming Maternity Care project that's sponsored by the Childbirth Connection and they had a series of lectures and one of the things that they focused on was payment for birth and other birth-related services and how you could change the incentives around birth to actually get the kind of outcomes that you need, and those are available on the web through the Childbirth Connection website.

CHAIR ROWLAND: Okay. David?

VICE CHAIR SUNDWALL: I want to keep up with my other provider friends. I've been very quiet here, but, you know, us doctors need a little attention too, physicians, and I'm not kidding.

[Laughter.]

VICE CHAIR SUNDWALL: I say this with a little guilt because at one time in my career I chaired COGME, the Council on Graduate Medical Education, when our policy was we now have or soon will have an excess of physicians, or we have sufficient, now may even have too many. Oh, my gosh, how the world turns, because a decade later, we do have a shortage, in my opinion, and I'm not sure that's the official COGME position anymore, but in the state of Utah, we're the 44th in the nation of population to primary care -- primary care to population ratio and it's a problem.

We do have an access problem because of physicians, particularly primary care, but also general surgeons and certainly child psychiatrists across the board, so we need to follow with interest what HRSA is now doing to reconsider how do they determine Medical Underserved Area, or Health Profession Shortage Area -- MUAs and HPSAs, but anyway, it's a big problem and I think Medicaid particularly faces an access problem if we don't have quality, well-trained, primary care and other providers to provide physician services to the Medicaid population. So, we need to keep that on our radar screen as well.

CHAIR ROWLAND: I guess the broad question that I'd put to the Commission members at this point is that we have developed this framework to identify the factors that go into access. We know that we're going to have to look at developing an early warning system and we're going to have to look at how well access is provided within the Medicaid and CHIP programs. Are we content with this framework as a starting point, knowing that it will evolve as our work evolves?

We're not making recommendations about were there access problems in this report, but obviously this framework would be used for us to be the underpinning for future recommendations as we go. So, let's be clear about whether this is where we want to start since we obviously went

through several models and several different definitions trying to get to where we had a working foundation for our examination.

Richard? Everyone comfortable?

VICE CHAIR SUNDWALL: Do we have to vote?

CHAIR ROWLAND: Nope. All right, then what -- Denise.

COMMISSIONER HENNING: I just have one comment, and this is more for the members of the audience, that maybe if you could just elaborate just a few sentences what we're talking about when we talk about the Early Warning System. Because we all know what we're talking about, but I'm not sure they do.

VICE CHAIR SUNDWALL: I'm not sure we all do.

[Laughter.]

CHAIR ROWLAND: Okay, let me just make one note. We are amended this per Burt's suggestion so that the next, so when we actually see it in the report, it'll have the amendments.

COMMISSIONER COHEN: And we --

CHAIR ROWLAND: And we will take out the word evaluation.

COMMISSIONER COHEN: Wait what are the --

CHAIR ROWLAND: The two bullets.

COMMISSIONER COHEN: The two bullets to add payment?

COMMISSIONER EDELSTEIN: Provider distribution and provider payment.

CHAIR ROWLAND: And to eliminate the word evaluating.

COMMISSIONER COHEN: Can I make a quick comment? Or I just -- I don't want --

CHAIR ROWLAND: Yes, you may.

COMMISSIONER COHEN: I don't want to belabor, but on provider pay -- I felt like the bullets under here are sort of measures of availability and provider payment affects, we think but we don't know exactly how, I'm not sure it's a measure of availability. So, I'm just going to ask, I may misunderstand, but Burt, what do you think about that?

COMMISSIONER EDELSTEIN: Well, in fact you could even say that provider supply is a subset of participation or visa versa. The reason I wanted to add them were because even though they are determinants of one another, they are so critical and we wanted to tie payment to access, as in our name. This is where payment is just such a critical element of provider availability, so, yes, there's some overlap, but I think that the model is more robust with the inclusion of distribution and payment.

CHAIR ROWLAND: And we're saying that in some cases, changing the way in which providers are paid can, through incentives or pay-for-performance, can promote broader availability?

COMMISSIONER EDELSTEIN: Diane, I appreciate that clarification because it's not just the amount of payment, it's the payment mechanism as well.

COMMISSIONER ROSENBAUM: Well, I would point out that that is the actual terminology of 1902(a)(30). That is the assumption, that 1902(a)(30) is really not about the ultimate point of access, it really is availability, and so that's, I mean, that gets to the core of the provision.

The statute actually never uses the word access. It talks about payment sufficient to ensure that providers are available to beneficiaries to the same extent that they're available to the general population.

CHAIR ROWLAND: The Medicaid statute?

COMMISSIONER ROSENBAUM: The Medicaid statute.

CHAIR ROWLAND: Andy?

COMMISSIONER COHEN: Now I'm being really picky and you can make me stop soon. So, provider payment -- I buy in 100 percent that without payment it is hard to find providers and therefore very hard to have availability.

But I guess I still -- I'm not sure that I see provider payment as sort of parallel to this question of supply and participation. Maybe this is more a semantic concern than really a substantive concern, because again I totally, obviously payment is related -- we know payment is related to availability, we just don't know exactly how. But again, are you saying, Burt, that we would -- one way of measuring availability would be looking at payment rates?

COMMISSIONER EDELSTEIN: Or more specifically, one component of availability, one primary driver, one primary determinant of availability, is provider payment, both rates and mechanism.

COMMISSIONER ROSENBAUM: Well, that's really the empirical question. I mean, that's what all the 1902(a)(30) litigation is about --

CHAIR ROWLAND: Is it or isn't it?

COMMISSIONER ROSENBAUM: -- which is the relationship between either payment outcome, the outcome of payment policies and do you get availability, or in some decisions, the question of whether the process by which you set the rate is really the focus of the law. But what Congress seems to have been convinced of in amending the statute is that there really is a relationship between how you set your payment and whether you're going to have availability that mirrors general availability. And I think we don't, we actually don't know that. That's the

problem.

VICE CHAIR SUNDWALL: Well, I would just like to go on record as saying that we do know, clearly, that the decline in primary care providers is directly linked to their opportunities for compensation and that is an access problem.

COMMISSIONER ROSENBAUM: Well, at a general level, absolutely. But to the extent that the issue is within Medicaid, whether the relative differences are what drive availability, I mean, as we know from some of the oldest studies, you can pay Medicaid providers actually as well as if not better than providers paid in the private sector and find that you still have more limited availability. So, that's the problem.

CHAIR ROWLAND: Lu?

EXECUTIVE DIRECTOR ZAWISTOWICH: Can I just ask a quick question regarding that box? When we talked about availability we were including measures in that box. So, for example, when we looked at availability we were looking at provider supply as a measure, we were looking at provider participation as a measure of availability, we were looking at provider distribution as a measure of availability.

CHAIR ROWLAND: [Inaudible.]

EXECUTIVE DIRECTOR ZAWISTOWICH: But when we think about payment, is payment a measure of availability or is payment a driver, a factor influencing availability?

So, I guess when we talk about those boxes, are we talking about measures or are we talking about influencers of those particular factors? So, it's -- I just want to get that clear as we move forward with the chapter because it is a very slight distinction, but a very important distinction. So, I'd like to open that up further for the discussion with the Commission.

CHAIR ROWLAND: And in the draft chapter we call them potential measures -- availability factors and potential measures of those availability factors.

COMMISSIONER COHEN: So, thank you for saying that so much better than I was able to. That's exactly what I was sort of trying to say, and I guess my point would be, we may discover after our analysis that payment belongs as a measure, but I don't think -- I'm not sure we're there yet.

COMMISSIONER EDELSTEIN: I think Sara's comments reflect the fact that we just don't know.

COMMISSIONER COHEN: Right. We don't know.

COMMISSIONER EDELSTEIN: And that to leave it out when we recognize that it is so fundamental is -- and knowing that it may be a measure, and that it is, in fact, measurable, would be to fail to reflect both the statute and the concern of so many provider groups.

COMMISSIONER ROSENBAUM: Well, and the peculiarity is that Congress has already assumed it. See, Congress has already assumed that payment is a measure of availability in the way 1902(a)(30) is written.

COMMISSIONER COHEN: A driver of.

COMMISSIONER EDELSTEIN: And we've talked about --

EXECUTIVE DIRECTOR ZAWISTOWICH: Payment is a driver, not a measure.

COMMISSIONER EDELSTEIN: We had talked about --

COMMISSIONER ROSENBAUM: Well, I'm not -- I'm actually not sure, because nobody's really probed. This is -- the work of the Commission is really to probe 1902(a)(30). We are probing it the way it hasn't been probed since it was written, and so the question is whether we

do something in the schematic to indicate -- or even in the text -- to indicate that we don't yet know how to express payments.

EXECUTIVE DIRECTOR ZAWISTOWICH: And I would propose for Commissioner consideration that it be done in the text, clearly indicating that it's a factor influencing availability but not -- but we are still -- haven't discerned the relationship between payment and participation.

MS. SIMON: Right, because now in the text we talk about how payment or reimbursement is one of the primary reasons why providers are -- may not be willing.

CHAIR ROWLAND: To participate.

MS. SIMON: To participate in Medicaid.

CHAIR ROWLAND: But it also may be why they're not in supply.

MS. SIMON: Right. Right.

CHAIR ROWLAND: It actually influences both.

MS. SIMON: Well, it's both, so that's why we would look at both.

EXECUTIVE DIRECTOR ZAWISTOWICH: And distribution, potentially.

CHAIR ROWLAND: Burt?

COMMISSIONER EDELSTEIN: I clearly hear the comments and understand them well. One of the things that we've talked about a number of times as Commissioners is not being seen as being out to lunch or unaware or uninformed about --

CHAIR ROWLAND: We eat lunch in.

[Laughter.]

COMMISSIONER EDELSTEIN: -- about the realities of the program, and we've mentioned that in a variety of contexts. I was looking for a way to tie our payment concerns and

our access concerns together and to put it squarely in the model in a way that says that payment does make a difference. It certainly influences supply and participation and distribution and it's the place where we're going to have our most fruitful work as we consider not just rates, but methods of payment.

I don't think that it would be valuable to try to tweak or mess with the model any further by finding some other place to put it, and I do recognize how it isn't a perfect fit, but it does seem that we are a bit out to lunch if it's not reflected in the model.

CHAIR ROWLAND: It seems to me that we have a problem though. If we put it in the availability side, then are we saying that payment doesn't influence utilization?

COMMISSIONER EDELSTEIN: Well, as I understand it, yes, because we want it to separate that set of factors that are provider driven from that set of factors that are consumer driven.

CHAIR ROWLAND: But I think utilization is provider driven as well as --

VICE CHAIR SUNDWALL: Well, it is. Let me just weigh in with Burt on this. I think it's too fine a nuance, Lu, to say it's a driver or a factor or whatever thing. I think the average reader looking at that is going to be quite clear that payment and distribution are factors in access, and then we can explain it in the text, but I think it's helpful, I really do.

COMMISSIONER ROSENBAUM: [off microphone] It's one part of access.

VICE CHAIR SUNDWALL: It's one. It's one of several. Yeah.

CHAIR ROWLAND: Okay.

COMMISSIONER RILEY: I think Andy's opened a can of worms and I'm more inclined to be with her worms because I think there's a knee jerk about -- you know, there's a knee jerk that more is better, that if you pay more, you'll get more, if you pay more, they'll be more available, and

I'm not sure that's where we want -- the point is, what we're trying to do -- aren't we trying to pay for -- it may be true, but what we're trying to do is pay for access. The measure ought to be paying for access it seems to me and the means to pay for access is you -- appropriate utilization, enough availability.

So, it seems to me the payment somehow connects to the bottom box, if at all, but I'm inclined to think it's definitely not a measure, it's the vehicle to get us access and access is both -- you may, you know, we brought the availability utilization scale, and the way you get -- and those are the two means to get access and you pay for access. So, maybe we need a little triangle that goes payment to access.

CHAIR ROWLAND: Or add it to the bottom of each strike evaluation.

COMMISSIONER RILEY: Yeah.

CHAIR ROWLAND: Norma? Patti?

COMMISSIONER MARTINEZ ROGERS: I work at a health science center and I can tell you that there are some doctors that it wouldn't matter how much --

CHAIR ROWLAND: They got paid.

COMMISSIONER MARTINEZ ROGERS: -- they got paid, there are some doctors that are very clear and say, I don't want to work with Medicaid patients. And they're very clear about it and in particular in the specialty areas. They don't. And, you know, I don't think that that paying the fee-for-service makes for -- I'm sorry, it doesn't make for accessibility.

CHAIR ROWLAND: Patti?

COMMISSIONER GABOW: I'm not going to weigh-in on this.

CHAIR ROWLAND: You're not?

COMMISSIONER GABOW: Except to say that if we're really going to get into availability, then -- and we want to list all possible variants on availability, I would say equally important is the delivery system and so if we want to expand this box, I would say, rather than starting into the granularity of what influences providers, I mean, you could say availability, I'm now violating what I said that I wouldn't, but if you want to say what is availability and service, it's really providers, it's supply, it's participation, it's payment.

So, it's providers-could be one line and the delivery model is another line, and it gets to what I was alluding to earlier that as long as we have in our mind that the delivery model is a face-to-face visit, we will automatically limit availability. But, so, we could play around with this and start adding things to boxes and taking things out, but I think we all knew that this was a framework in evolution and that we were going to put something up that the two main -- I mean, I think the main point of this framework is not so much what's in the little boxes as what's in the big squares, that what we knew -- I mean, what we are putting out as a framework, I believe, is that enrollees have a set of characteristics that are very important in this program.

The availability of care is going to be really important and how that care is utilized is going to be important in leading us to access.

And so, maybe, rather than spending a lot of time with what's in the little boxes, is to take the little boxes out and just to say that we are really -- that our framework is really the big boxes.

VICE CHAIR SUNDWALL: See, it's not clear in looking at that that those are necessarily measures. I mean, no one ever said that. So, if we're worrying over are they measures or factors, let's just do away with the boxes.

CHAIR ROWLAND: Okay, so here's a proposal. We take -- we leave the words under

"enrollees" and under "access" because those are defining the top and the bottom points, and we strike the boxes under "availability" and "utilization" and deal with that in the text where we can have a broader discussion. Agreed?

MULTIPLE PARTICIPANTS: Yes. Absolutely. COMMISSIONER CARTE: Yeah, because we were just driving ourselves back into the weeds because last time we basically asked the staff to simplify and they've done that. But now we're going back there, so --

CHAIR ROWLAND: Now we're going simple again.

COMMISSIONER HENNING: If we are going to do that, can we just -- on the very bottom line where it says "health outcomes", can we put like positive health outcomes or, you know, something along the lines to -- I mean, it could be any outcome and we may not -- you know?

CHAIR ROWLAND: But it could be that if we're doing an Early Warning System, a negative outcome would be important.

COMMISSIONER HENNING: True. Okay.

CHAIR ROWLAND: Okay, so the model, once again, is back on a new iteration, simplified, and we will now take a break and reconvene at 3:15.

[Recess.]

CHAIR ROWLAND: We always save the best for last. So here comes April, and obviously as we look at all the issues that are before us, on our plate for MACPAC, one of the issues that comes up the most is what data will we have to be able to be data-driven and to answer questions with quantitative analysis instead of just impressionistic work, to what extent can we get state-specific information as opposed to just national trend information and what is the role therefore of the administrative data systems.

As you will recall from the last meeting, there are other sources of data, survey data and individually collected data, that we will get to at a later point, but today we wanted to focus on the administrative data set. This is a big initiative of CMS to try and clean this up, and April is going to take us back to the data chapter and to administrative data to try and assess what the needs are and what kinds of questions can be answered.

April. ###

IMPROVING MEDICAID AND CHIP DATA FOR POLICY ANALYSIS AND PROGRAM ACCOUNTABILITY

MS. GRADY: Thank you, Diane and good afternoon, everyone. I hope you're not tired of seeing me up here. I feel like I've given some version of this talk to you several times, so look forward to doing it again.

We're going to talk about the March chapter on data. As Diane mentioned, we've narrowed the focus to look specifically at federal administrative data this time around, and there are sort of three key points that we hit on in the chapter.

The first is that Medicaid and CHIP data are critical for answering policy and accountability questions. This is something that we heard from you over and over again--is that we wanted to know what these data are being used for, what we can do with them, what questions we can answer. As part of that section, we provide background on major sources of federal administrative data on the programs.

We then talk about improvements to the data that are needed, and we give specific examples of the kind of policy issues that could be addressed with better data.

Then I'll talk about how we are going to move forward with data issues in the future.

In terms of the data themselves, as you've heard, states report data to CMS on a variety of things--enrollment, service use and spending. They also report on program policies such as eligibility levels and covered benefits.

And these data can be used for a variety of purposes, and in the chapter we've sort of bucketed them into three broad categories--looking at access, looking at the value you get for spending on the program and also program integrity issues. And examples of the kinds of questions that fall under these broad buckets are whether enrollees receive appropriate care, which policy choices most affect that care and its cost, and whether legislators and administrators have a clear picture of how Medicaid and CHIP dollars are spent.

Now I don't want to oversell the data because part of the issue that we've identified and that others have identified for you is that the data are not perfect. There are some improvements that could be made. Some of the things we've talked about are increasing the level of detail that's available for managed care and for separate CHIP program enrollees, where the information is a little bit thin right now. We've talked about providing data that are more timely and that are more consistent across sources. And we've talked about making program information--information on state program policies--more readily available.

You've also heard some about CMS efforts that are underway to modernize their computer and data systems with input from the states and other stakeholders, and I just wanted to highlight that in a report that CMS released in late December they noted that they're planning to convene a state panel to make recommendations to CMS this year about developing a data strategy for Medicaid and CHIP that lessens the burdens on states but also recognizes CMS's need for standardized information. So they'll be gathering input directly from the states, and I know that

was a concern we heard voiced from the commissioners on a number of occasions.

In the chapter for each of the areas for improvement that we talk about, we highlight examples of problems and issues that could be addressed if we made improvements to the data, and the point here is to be as concrete as possible. We're not collecting this information just for the sake of collecting. We want to talk about how it would actually be used. And I know that has been a recurring issue for the Commission, and that's something we can talk about further emphasizing if that's something of interest.

Here, I'll just hit on a couple of these. We've talked previously about how CMS could directly calculate measures that are reported elsewhere if they had better information on people in managed care. For example, there are separate reporting requirements for children right now that can only occur from the state level. If CMS had access to better federal information, they could eliminate some of that state reporting in other areas.

Again, managed care encounter data could allow us to look at care received by different populations--people who are in managed care versus fee-for-service and people who are in Medicaid versus separate CHIP programs, which do have different benefit packages. Many of the states are doing these analyses on their own, it's important to point out, but again if we don't have information at the federal level it's hard to have a national picture, or a cross-state picture, of these issues.

One of the other issues that we've touched on is program integrity. If the federal government had better access to timely information, particularly around the claims paid by states, they could also be using that data to look at potential fraud and abuse issues on top of what states are already doing. Again, they do do a substantial amount on their own.

So that's just a quick summary of the chapter, which again you've heard about on a number

of occasions.

We're going to continue to monitor and make use of the data that we've been talking about, the federal administrative data, and we're also going to use additional data sources in the future. For example, we talked a little bit about survey data that allow comparisons of Medicaid and CHIP to other forms of coverage. One of the potential shortcomings of administrative data is that it only tells you about Medicaid and CHIP; it doesn't tell you about private insurance; it doesn't tell you about other forms of coverage.

And then as Patti and Jim mentioned during the payment discussion, and it also came up during the access discussion, we'll also be looking to special studies that collect data for a targeted purpose. So as we see the need for delving deeper into certain issues we'll be able to do that analysis and think about collecting information, primary collection of information ourselves.

Thank you very much, and I look forward to your comments.

CHAIR ROWLAND: Thank you. Comments?

COMMISSIONER HENNING: The only comment I have on this chapter is that I really think that we should encourage SKMS to look at when they're instituting the EMRs and defining the meaningful use that--

CHAIR ROWLAND: Okay, define. You have to do EMR [Inaudible].

COMMISSIONER HENNING: Oh, okay. I'm sorry. Yeah, really, I'm the one that said about the acronyms, right?

Okay, the Centers for Medicaid and Medicare Services, I think I got that backwards, but--

CHAIR ROWLAND: But we are the Medicaid Commission.

COMMISSIONER HENNING: Yeah, that's right.

Now there's a push for electronic medical records, which is what EMR means. Then what they say is that in order to qualify to get additional money to help purchase systems and encourage providers to actually institute electronic medical records, because as we all know that can be a really expensive endeavor, they have a set of conditions of things that those systems must do. And one thing that is not on the list is coming up with a way for those systems to collect aggregate data of the patients, so that you could maybe report to the state how many visits a diabetic population has on average through the course of the year, or how many times was that patient seen in the office as a follow-up to an ER visit, or how many times did the patient go to the ER.

There's no--the systems are typically really good about keeping track of the patient individually but not pulling data together, so that you can look at it and crunch the data and make some kind of reasonable policy conclusions. And it would be really good, since we're beginning that process in the country, of moving toward electronic medical records, to think about at the ground floor let's have that as a basic consideration--is don't we want to have that ability to do that.

CHAIR ROWLAND: Good point. Trish.

COMMISSIONER RILEY: I think we've done a nice job focusing on the importance of the questions in some of the discussion this morning, to make sure we know what we're getting data for and issues of redundancy and value, but I would urge us to do a little bit more in the report about the burden.

Certainly states absolutely should be reporting timely, accurate data; there's no question about it. But I think we've got to be very understanding in the narrative about the burden now on states. They're doing ICD-10. They're doing meaningful use. Before we ask states to do something different in how they report, it's got to be clear how it's going to be used and that there's

an understanding of that burden and what they're able to do, or what they'll be relieved of doing.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Well, at risk of revisiting the same issue that actually came up at the last meeting, I will just add on to Trish's point and make a plea that where the federal government is able, through the MIS system, to extract the data that it needs I do not understand why states are having to generate all of these reports.

VICE CHAIR SUNDWALL: That's right.

COMMISSIONER ROSENBAUM: In other words, it was the same point I tried to make that I think was not well understood last time, and that is that the advances we have in information technology now, putting aside the kinds of issues actually that Denise is raising, should enable the federal government to assemble data and then decide how it will use the data. It was the point that Patti also made last time about how a large health system does it.

And so the notion that we are still expecting, or that the federal government is expecting, the states to generate reports seems to me so antiquated compared to how the vision that we might want to bring to data, which is we have a lot of data and a national partnership between states and the federal government should prioritize the data that will be collected or be pulled up for analysis. And this notion of a passive federal government sitting back and waiting for states to generate reports, I think is just outdated at this point.

CHAIR ROWLAND: Okay. Judy.

COMMISSIONER MOORE: I think that April has mentioned, and the chapter talks about, the things that the federal government has under consideration and underway. But building on the comments that Trish and Sara have made, I do think that we need to look to the federal

government to do as much as they can possibly do.

People have talked about the number of states that have encounter data, but it just sits in the state. Now the state probably uses it for a lot of useful, interesting things, but it would be very helpful to have as much of that as possible in the hands of the federal government and in the hands of the research community and in the hands of those who could use it to do things across states, not just within one state.

And I know there's a lot more to it than what I just made it sound like, but I do think that we need to encourage the feds to do the maximum amount they possibly can with what they've already got and what they know the states have that they could more efficiently manage and make available.

CHAIR ROWLAND: Okay. Norma.

COMMISSIONER MARTINEZ ROGERS: I think also that if we're asking the states to provide this information and the federal government then has an obligation to tell the states what it is that they did with it, give them some type of summary. People don't respond to these because somewhere or another they believe that it's just stored some place, and no one ever follows through to give them back feedback. So I think that if you want, if you value this information, you're asking states to do it, you say it's important, then they need to say this is what we're going to do with it and follow through with that.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: David?

VICE CHAIR SUNDWALL: Sorry.

COMMISSIONER HOYT: Maybe just a topic for the parking lot or future work, I don't

know we're going to address the duals quite a bit in the future. I think that would be a specific area where the feds or CMS could really help out a lot. Mercer has done some projects on duals for various states, and that is no trivial task, to try and run these matching data sets, to pull the data together from both sides for the people who are in both programs. I'd love to see us revisit that at some point.

VICE CHAIR SUNDWALL: Could I just inquire? It seemed to me the staff, if you recall, did we -- Lu, did we agree as a group to kind of inquire from the Medicaid directors group or others if there was agreement on what was considered redundant or overburdening reports. And I don't know if it's premature for us to acknowledge that, but I think it would be something the Commission could help with.

EXECUTIVE DIRECTOR ZAWISTOWICH: What we agreed to do was to follow up with some of the staff at CMS, and actually CMS has just embarked on an effort where they're working with the states as part of their strategic effort to look at data. So we've followed up with CMS. We've talked to several state Medicaid directors about our data chapter and have had some feedback, both on our chapter, and I know that CMS is working individually with the states on their strategic plan.

CHAIR ROWLAND: This was sent out for review to some of the states as well.

EXECUTIVE DIRECTOR ZAWISTOWICH: Yes, it was sent out to several states as well as CMS.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: Was there any concern at the state level about having more federal government oversight of the data collection piece, do you think, or were they looking

forward to getting more data from the feds hopefully back.

EXECUTIVE DIRECTOR ZAWISTOWICH: Well, just to recall, what our chapter does is to really lay out what data would be used for -- you know, some of the kinds of questions that would be answered by it. It's really a compilation of all the administrative data sources that CMS collects. We then conclude by supporting some of the CMS efforts in developing a strategic plan.

I think, by and large, the states that responded felt that we did a really nice job of describing those efforts. And they believe that data that could help states run their own programs better, as well as allow the federal government to have a better understanding of state programs, was something that was in everyone's interest.

CHAIR ROWLAND: Andy.

PARTICIPANT: Uh oh, it's Andy.

[Laughter.]

COMMISSIONER COHEN: And in fact, this is going to be so uncontroversial, you're going to be upset, and maybe even a little bit of a silly point, but in an effort to sort of be really disciplined about drawing our sort of data discussion really closely linked to our discussion about substantive topics and the questions that come up.

I almost wonder. Maybe this is a technique that you can use in your daily work, and may be or may not need to be reflected in our published work. But in the chapter on payment, in the chapter on access, there are -- and even in the earlier, in the framework chapters, there are issues that are raised that point out the issues around data. Well, you know, the charts for example and MAC stats and other sorts of things. You know. As a discipline, if we can sort of remember to sort of always flag these questions that come up and issues around data in our substantive work, it

can help, I think, give us good direction on how to prioritize on the data side.

CHAIR ROWLAND: Other questions? Comments?

April, I think it's also important that within this we do stress that some of the data that the federal government collects is for the purpose of determining their share of the payment for services and that obviously that is a foremost concern for the federal government to get whatever data it needs to actually substantially verify payment. What we're also doing is talking about additional ways in which the administrative data set can help make other determinations, but first and foremost has to be the payment requirement. So some of the things states consider burdensome may be required for payment.

Okay, so --

VICE CHAIR SUNDWALL: One last statement. I just want to say how pleased I am with this data report. It's very informative. It helps people understand how complicated it is and why we all need to work towards simplification, but it also shies away from saying if we only had so much more money we could do the job. So I think that we need to work within the reality of the budget times and improve what we can within existing resources and work with CMS, but there are opportunities for real improvements here without necessarily large appropriations to get that done.

CHAIR ROWLAND: Thank you, April.

And with that, we will open the meeting to public comment. If anyone would like to address the Commission, please come to the microphone and identify yourself and your organization for us. Thank you. ###

PUBLIC COMMENT

DR. SIEGEL: Thank you, Madam Chair. My name is Bruce Siegel. I am the CEO of

the National Association of Public Hospitals and Health Systems, and I'm actually grateful for the opportunity to be able to talk to you today. About half of the care provided by our 140-member health systems is in the area of Medicaid and to the uninsured. So obviously, the issues you're talking about are of great concern to us.

Your charge is an important one obviously, to advise Congress on Medicaid and CHIP issues, and also to report on the implications of changes in health care delivery on these programs. You also have a lot of tasks involved in this around coverage and quality and eligibility.

At NAPH, we urge you to really weigh in at a time when the Medicaid program is under severe jeopardy from the immense fiscal pressures being felt by the states and the federal government. In New York, Florida, Texas, Wisconsin, California and other states, we're seeing a debate on the future of Medicaid and access to care for low income Americans, and many proposals are now being floated which would involve removing hundreds of thousands of Americans from Medicaid eligibility.

Medicaid is coverage, and as the IOM found in 2009, coverage matters. Not having insurance is tied to later diagnoses, poorer health and even death, and even having low rates of eligibility for Medicaid and high rates of uninsurance can be tied to poorer care for insured adults in the same communities. Medicaid is a keystone to vulnerable populations and the providers that serve them, and it meets the needs that a private market cannot and will not meet.

We would suggest that MACPAC should, at the very least, develop a set of principles to guide policymakers in making decisions about the future of the program to ensure that it continues to serve this vital role. All proposals to cut Medicaid, especially eligibility, should be measured against these principles, so that access to care is protected for the poor, the disabled and the elderly,

all of whom rely on Medicaid for their health and well-being.

We fully understand that you're just getting started. You have a lot on your plate, and you may not have enough data yet to make recommendations about the impact of the various proposals that will emerge this year. Nevertheless, the debate on this in the short term, today, is too important for the millions of people who depend on this program for any of us to sit it out.

Thank you very much.

CHAIR ROWLAND: Thank you for your comments.

COMMISSIONER ROSENBAUM: Can I ask you a question?

CHAIR ROWLAND: Yes, she can.

COMMISSIONER ROSENBAUM: Yes, I got permission. I got permission from the Chair.

So I wonder if you might elaborate a bit, if you have information just sort of readily at hand, about what your members are bracing for at this point, if anything.

DR. SIEGEL: Sure. We've actually talked a lot with our membership about this because this is, I think, a difficult discussion for many of them, especially around eligibility, maintenance of effort around eligibility. And I would say that resoundingly our members have said that eligibility should be maintained. They realize that others may pose tradeoffs to them in their local market, that if you don't do this you may see payment cuts and other things. But I think their belief is (A) that this is important and is the right thing to do, given our mission, and (B) these other things may because of local political dynamics be caused to happen regardless.

So I think there's been a pretty firm line from our membership around this issue, and I think many of them hope that in their states they can work out some of these things without removing,

literally, all these people from having insurance coverage.

CHAIR ROWLAND: Any other questions?

You mentioned developing principles. Have you got an example of what such a principle might be?

DR. SIEGEL: Well, I think we didn't come ready with that today, and that's a great question. We would be happy to work more on that. But we would be really interested in thinking about principles around what are the impacts on individuals' heath, what is the impact on various chronic conditions, what are the impacts on many of the things that you probably are talking about today around access, to fully understand those things.

CHAIR ROWLAND: So the access framework that we've been talking about would help develop some of those guideposts.

DR. SIEGEL: Yeah, I think that would be a great starting point, and I think you perhaps have a lot of that work already done. I think our plea today is more a sense of urgency, that many of these things I think are unfolding literally as we speak. And we think that we'd hate to see honestly harm done to the trajectory of what we think is a positive trajectory around reform, which we supported, in coverage in the short term.

CHAIR ROWLAND: Thank you very much.

DR. SIEGEL: Thank you.

CHAIR ROWLAND: Patti.

COMMISSIONER GABOW: I think that your points, Dr. Siegel, are well taken because I think while we as a Commission didn't feel we were ready to make recommendations. I think we are sitting in a very critical time probably for the Medicaid program, and probably I think it would be

wise for us to spend some at one of our meetings thinking about can we develop some construct, maybe within the guidelines of our framework, so that the framework can be used.

I know none of you can believe that I'm talking about the framework.

[Laughter.]

COMMISSIONER GABOW: I can see Richard is laughing.

Now we can use --

CHAIR ROWLAND: For those in the audience, Patti has not been one of those whose early embrace of our framework was there. But now she's on board and she's created a new thing.

COMMISSIONER GABOW: You know, as I said earlier, my grandmother always told me if you live long enough you'll see everything.

So that we can use our framework not only to guide our work but in some ways develop a framework that others can use to design their decision-making and think about as we continue to work on the framework, that we think of it in both those ways.

I would also say that to the issue of eligibility and people off-rolls, I mean they are obviously linked to the burden of the uninsured and what that means economically.

I think Denise was alluding to this earlier, that patients get care one way or another. So it's, I think our desire that they should get care in the least expensive site with the best outcome. And just dropping them off the rolls doesn't mean they're going to disappear. They're just going to appear in our emergency department, and certainly we know that during this period of economic downturn we've seen a big increase in emergency room visits and all the consequent issues that happen, not just to the Medicaid and uninsured, but I know that we faced a big issue about capacity and divert. Well, when that happens, everybody gets affected -- commercial patients, Medicare

patients, not just Medicaid. So I think understanding the domino is important as well with this.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: That was my question. Kind of a corollary for you, Doctor, is with your association, obviously your public hospital members don't exist in a vacuum. Are they having discussions in their states and communities about this impact?

DR. SIEGEL: They're having very extensive discussions, and I think in our discussions with them. You know, many of our members perhaps don't look like the usual community hospital. They have large ambulatory networks. They often have an affiliated health plan or Medicaid health plan. They have a continuum of care which is often seen in most other settings.

And I think two things are happening there. One, they believe, as Dr. Gabow, has mentioned, that if people are removed from the rolls they're still going to see them in many different touch points in their community. The second, I think they're very excited frankly about innovations that are being talked about in terms of providing better care at lower cost and are embracing those. And I think their concern is let's have that discussion about doing it better rather than a discussion of essentially just saying people shouldn't have coverage in their short-term. So I think they're much -- they're prime to have that dialogue and actually do things about it.

COMMISSIONER CARTE: Thank you.

VICE CHAIR SUNDWALL: May I speak?

I thank you for your comments. I have long known of your organization and respect what you do. You're just an integral part of the nation's safety net -- very, very important.

One thing I think I would like you and your organization to understand is the Commission is not an advocacy group. We do not intend to promote policies that might be considered across the

political spectrum.

What we want to become, and I think are on track to do that, is a source of sound, reliable information, data, historical perspective, where we are now, some of the challenges we face. But we are not inclined, I think, to lend ourselves I think to a particular policy position just because I think we might then lose some credibility with those we report to, and that is the Congress, across the political spectrum.

So I understand what you're saying. I would certainly like to see the principles that your organization develops. I think they ought to influence how we behave and what we do, but just so you understand that I think we intend to be a source of really good information but not to be an advocacy group.

DR. SIEGEL: Yes. If I might, we completely understand that, and I think that we're not asking for you to do that. We understand that.

When I hear about the early warning system, for instance, I think our members are very excited about that as a source of objective information. We just wish we had it yesterday, and that's what you're hearing.

CHAIR ROWLAND: So do we. We can all agree on that. We wish it was something that magically came down to us, but we think it will be an important contribution. And thank you for your comments.

Are there other public comments?

MS. BRENNAN: Good afternoon. Thank you, Madam Chairman. My name is Cate Brennan, and I'm with the National Athletic Trainers Association. We're based in Dallas, Texas.

And for those of you who may not know exactly what athletic trainers are, we're the allied

health care providers who do injury prevention, diagnosis, assessment and treatment and rehabilitation. We have about 40,000 members throughout the U.S.; 34,000 are members of my association. Many of them work in the secondary schools. So I would urge the Commission and the staff to take a look at some of these other alternate health care settings that many Medicaid children are receiving services.

Currently in very few states, athletic trainers are reimbursed through Medicaid, but many of those services are provided by the athletic trainers, just like the school nurses. So I would urge the Commission to take a look at that, and when you're counting people as important as primary care there's also a lot of the allied health support staff that go along with it, who are working in remote locations via protocols or guidelines under physician direction.

And secondly, I would also urge the Commission that wherever possible, on payment reform or analysis, to look at some of the innovative systems and some of these other delivery systems available.

CHAIR ROWLAND: Well, thank you. There is a strong constituency on the Commission that looks at going beyond the medical model and the physician model. So we thank you for your comments, and we will take those under advisement. Thank you.

MS. BRENNAN: Thank you.

CHAIR ROWLAND: Additional comments? Going once, twice.

Well, we thank the audience for coming to join us for this discussion. We hope you will embrace and enjoy our report that is due out on the 15th of March. It will be posted on the MACPAC web site, so that you'll have availability there. It will include not only the chapters that we've reviewed but the MAC stats which will be a nice compilation of state-by-state information on

a wide range of issues related to Medicaid coverage and to CHIP.

And we will be, immediately after releasing this report, working toward our June report and will continue to take many of the issues you've raised here today on the safety net, as well as on allied health providers, into account as we move forward.

But stay tuned. The report is coming, and future reports will be there too, and future meetings. So thank you very much for joining us.

And we're adjourned to executive session.

[Whereupon, at 3:55 p.m., the meeting was adjourned.]