# MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

Hall of States
National Guard Association of the U.S.
One Massachusetts avenue, NW
Washington, D.C. 20001

Thursday, April 14, 2011
1:28 p.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
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ROBIN SMITH
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LU ZAWISTOWICH, ScD, Executive Director

AGENDA PAGE

P R O C E E D I N G S [1:28 p.m.]

CHAIR ROWLAND: If we could please reconvene.

I want to welcome our guests and thank you for coming to join us today. We're now convening the public session of our MACPAC meeting today, and a topic for our meeting in our post-March report days has been to look at the challenges ahead for our June report and to begin to examine managed care and the role of managed care within the Medicaid and CHIP programs so that we can have that as one of the parts of our report to Congress in June.

I'm going to ask Lois Simon on the Commission staff to start by just reviewing sort of where we are as a Commission on looking at managed care, and then I'm going to turn to our panel and introduce them.

So, Lois, if you would just review briefly the work that we have entertained to date on managed care so that we have a setting for this discussion. Thank you.

**#### REVIEW OF MACPAC DELIBERATIONS AND WORK TO DATE ON MEDICAID MANAGED CARE AND HEALTH PLAN PERSPECTIVE**

* MS. SIMON: Certainly. Thank you, Diane.

Medicaid managed care has been one of the Commission's top priorities from the beginning. Since we spent so much of the past two meetings really focusing on the March report to the Congress, I'm going to provide, as Diane said, a quick overview of MACPAC's work on managed care to date.

Work on the topic began in the fall of 2010 at the first public meeting in September with presentations from two Medicaid directors who talked about access to care and provider participation issues in their programs, and a number of presentations on Medicaid managed care have been convened at public meetings since.

In addition, we have also initiated a number of activities to better inform the Commission on issues that exist in managed care programs, which I will briefly summarize. And, you know, given the dominance of managed care in today's Medicaid program and the recent state trends towards expanding their Medicare programs, as Diane said, the Commission has decided to focus on Medicaid managed care in the June 2011 report to the Congress.

At the October meeting staff provided a general overview of Medicaid and CHIP managed care. We highlighted some of the reasons why states pursue managed care for their Medicaid and CHIP populations, discussed trends in the most common models of managed care, as well as some of the unique characteristics of Medicaid that can make managed care challenging for both states and plans.

At the December meeting, we had a deeper discussion of managed care issues focusing on what is known with regard to access and payment. We presented a proposed work plan for MACPAC's future analytic work in the area, and this work plan was designed to gain better understanding of the key characteristics of state programs to be able to make comparisons across states as well as track trends over time.

The meeting also included findings from a literature review on Medicaid and CHIP managed care. The review synthesized what is known about how states implement and monitor their programs, and managed care's influence on enrollees, access, outcomes, and program costs. A key finding was that most of the research on the topics date back to the early 2000s, indicating a gap in information on current characteristics and program performance. Also, the results are mixed and varied, making comparisons difficult.

We also shared findings from an expert roundtable discussion on Medicaid managed care that was convened in mid-October. A panel of 16 experts with a range of relevant operational and research experiences shared their insights and perspectives on the current and likely role of Medicaid

managed care, as well as issues such as provider adequacy, payment, and access and quality monitoring.

Gaining insight from states on how they implement, manage, and monitor their managed care programs was also important in our review of Medicaid managed care, and we appreciate the input we received from state Medicaid directors at our public meetings. They have provided a unique, on-the-ground perspective that helps us on issues common across states. This is an example of some of them on the screen.

And so today we are interested in learning about managed care plans, their key concerns as well as key opportunities and challenges they see for the future. I will turn it to you, Diane.

CHAIR ROWLAND: We now are really pleased to have the ability to hear from the associations representing some of the major managed care plans that provide services to the Medicaid and CHIP population, and I'm pleased to have Meg Murray, the chief executive officer of the Association for Community Affiliated Plans; and with her Mark Reynolds, the chief executive officer of the Neighborhood Health Plan of Rhode Island, and one with great Medicaid experience from many states we know as well; and with Candy Schaller, the senior vice president for regulatory affairs at America's Health Insurance Plans, or AHIP, as we know it; accompanied by Michael Rashid, president and chief executive officer of AmeriHealth Mercy Family of Companies. And you will note that Michael has given us some testimony that is now being distributed to each of you at your table, but I am going to ask Meg to start our discussion, and I think there are slides available in your packets from Meg as well.

* MS. MURRAY: [off microphone] Great. Thank you, Diane. Can you all hear me? No. Okay.

All right. That was the first instruction that I did not follow. Anyways, thank you very much for having us here. You can all hear me now? Great.

I just wanted to give some context of who ACAP is. Some of you may or may not know who we are. We represent the nonprofit safety net health plans that are focused on Medicaid. About half of our plans are also in the Medicare space as the special needs plans. But you can see from the map that we're in about 26 states now, and with 54 plans we represent about a third of all the people in Medicaid managed care. So we are distinguished from our colleagues at AHIP by the nonprofit focus and being focused solely on -- primarily on Medicaid.

This is the list, in case you're interested if there's one in your state. A lot of people are also interested in where these plans come from, and a lot of them are from providers, from CHCs or hospitals; a lot in California were set up by governments, and two in New York were set up by home care agencies.

When Lu and Diane asked me to talk about the challenges of Medicaid managed care, my staff and I came up with a long list. We did whittle it down. But we realized that there were really two buckets of challenges, and so I wanted to focus my talk today on these two challenges.

The first are the welcome challenges. The reason that the providers, the CHCs, and the hospitals set up these plans was to reform the delivery system. And so the first set of challenges, I will talk about that and what our plans are doing to meet that.

The second set of challenges, however, are the ones that the states and the Federal Government have put in front of us, which is making it more difficult for us to achieve the goals of these challenges. So ACAP has proposals in place to address some of these, and I'll talk about them throughout the talk.

But the first challenge, as you all probably know, when Medicaid managed care was set up, it was mostly for moms and kids, and then in the past maybe ten years, more and more states have put the disabled, the SSI population into managed care, and that has really been a fundamental shift for our plans. These are chronically ill people who have significant care management needs, and the

transitions of care issues are very complex.

I wanted to start with just an example from one of our plans in Kansas City, Children's Mercy Family Health Partners. They had an example where there was a mom who had a child with autism spectrum disorder and seizures, and she was having a lot of problems with the child, and the child was going to the ER a lot because of the seizures. And as a mom, I can imagine if your child has a seizure, you want to just get to the ER. But the care manager at the health plan was able to step in and educate her on how to deal with the seizures in the home and when to know when she really needed to go to the emergency room. And I think that's a good example from a children's perspective on ways that health plans can address the issues that the families face potentially on a daily, weekly, or monthly basis, and keep people out of the emergency room.

There was another example from one of our health plans in Colorado of a woman who was developmentally disabled. She also suffered from diabetes and asthma. Her parents also had some similar health and behavioral issues, and she was going into the ER and into the hospital frequently. So, again, our health plan was able to step in with the help of a care manager and get her a primary care provider. She didn't have one, so there was nobody really managing her diabetes. They were able to get her preventative care, including family planning services, and they were also able to hook her up with someone in the community to teach her independent living skills so that she was able to eventually move out on her own. And as a result, again, she is not in the ER, not in the hospital, no unplanned pregnancies, and living on her own.

So these are the kinds of things that plans can do with the help of their care management staff.

These new populations that are coming on in 2014, they're going to look a lot more like the SSI population that our plans are currently seeing than the TANF population. And so our plans are currently working to make sure their care managers -- that if they're not in the SSI program,

they're now learning from plans, like Mark's and other plans, that are doing some form of care for the disabled, and they will be adjusting their care management systems to deal with the needs of the more chronically ill.

ACAP has done some research to show that if states put everyone that they could put -- the non-dual eligibles into managed care, so that the rest of the TANF and the non-dual disabled population into managed care, the states and the federal government could save $83 billion over ten years, which is obviously a significant sum in this time of deficit reduction.

To the extent that the SSI population changed our plan significantly, the inclusion of long-term care into managed care is also what one of my chairmen just called yesterday "a game changer." As Andy know, in New York they're putting long-term care into managed care, and so the plans there that don't do it currently, it's going to fundamentally change the way that they do business and what their emphasis is on. And one of the challenges I just wanted to put out for you all to think about is how to set rates for long-term care. You want to make sure the rates are set in such a way to incentivize the plans to keep people out of nursing homes and to be able to afford to give them the home and community supports that they need. So that's a real challenge in terms of that.

Eleven states today do some form of long-term managed care, and another 15 states were just given the grants from the Office of Dual Eligibles. Today that was announced. So there's going to be a lot more states looking at long-term care in managed care, and certainly the challenges of rate setting are ones that we need to keep our eyes on.

Another really big issue for our plans is the integration of Medicaid and Medicare. As I said, about half of our plans are in the special needs program, and as complicated as the issues are for the SSI population, when you throw in a whole other program, it further complicates it. So there are the challenges of basically having one plan and one person but two programs. And I

think a real good example that a lot of our plans dealt with was Medicare -- for the Medicare Advantage program, they want to make sure that the customer service programs in the plans are working appropriately, so they do secret shopper calls. They called one of our -- actually, a couple of our plans, and they said, "Do you provide dental?" -- pretending to be a dual eligible, and, "Do you provide dental?" And the plan said, "Yes, of course we do. That's something that we give." Well, that was the wrong answer from Medicare's perspective because Medicare doesn't cover dental. And so our plans got dinged on that. But the reality is that our plans did cover it, either because the states offered dental through the Medicaid program, or in some cases our plans actually offered it themselves out of the savings.

And so that took a long time -- I think Richard was a part of that discussion -- to unravel why our plans should not be being penalized for answering correctly for the person. They answered incorrectly for the program, but correctly for the person. So there's a lot of complexities between the two programs in terms of things like that -- grievances, a number of areas.

There's also just not enough people in the dual-eligible population today in managed care in order to be able to really support the care management that these people need. The average size of our plans in terms of their enrollment of duals is probably a thousand. And it's very hard to be able to establish what you need to in order to care for them. And so one of the things that ACAP has called for is mandatory enrollment of the dual eligibles on both the Medicaid and the Medicare side. We also agree, though, that people should have the option of opting out. It is just the default should be into managed care and into the supports that that provides, and then people should be able to opt out of that.

We know that care management works, though. We had a case from our health plan in San Matteo of a woman, she was about 56. She was obese, she had heart disease, she wasn't getting the care she needed, and so she was in and out of the hospital. So our health plan stepped in and was

able to get her a physician who actually came to her home, gave her some primary care in the home. Home health aides were able to come in and help her, and then the plan was also able to get her transportation so she could see a specialist outside and was able to get a church involved in her life so that people from the church would come in and make sure she was doing okay and just in terms of socialization. And as a result, she -- before that happened, she was well on her way to living in a nursing home. But as a result of the social supports that the plan was able to get in place, she's still in her home and not in the hospital as much.

So ACAP, as I said, is proposing that all dual eligibles be enrolled in Medicaid and Medicare managed care, and we believe that that would save $145 billion over ten years to both the states and the federal government. And we have and we can share again those documents with you all if you would like to see more about that.

A lot of the challenges that our plans face in terms of system reform have to do with integrating long-term care and acute care, Medicaid and Medicare, but also behavioral health and physical health. And I think Mark is going to talk more about that, but I just wanted to lay that out as one of the challenges. For a lot of people who have severe and persistent mental illness, they're taking certain drugs that have physical health side effects. And many people then are seeing behavioral health providers on one side and providers on the physical health, but the providers don't even know about each other necessarily and certainly don't talk to each other. Again, that's something that the health plan, because of seeing the claims coming through and the drug information, would know that that's happening and could have a care manager step in.

One of our health plans in Massachusetts has care managers whose sole purpose is to work with people who have had a behavioral health hospital admission, and then they make sure that when they come out of the hospital that they make a call to those beneficiaries, make sure that they have the right medication, that they have the physician and the clinical support and also the social

support. So that's kind of the care transitions that we had talked about is expensive but necessary in order to keep people out of the hospital.

So in terms of all these challenges, really, it's all about improving quality while controlling costs, and they are not mutually exclusive. We believe that with managed care we can achieve the triple aims of Don Berwick.

So those are what I said are the good challenges, the challenges we welcome, the challenges our plans and their provider owners wanted the plans to do when they were established. But the bad challenges or less welcome challenges have to do with things that are in our way. And really in many ways, they all come down to the issues of rate setting. I'm sure you're not surprised at that. But as you probably know, the federal government does require that the states pay plans on an actuarially sound basis. That was part of the BBA in 1997. But we also know that it's observed more in the breach, unfortunately.

Right now, for instance, our plan in Oregon, Care Oregon, is facing a 19-percent cut that the governor just proposed. Well, that is, I think, clearly not actuarially sound, but it may go through. And we have lots of examples like that in lots of states.

For our plans that do only Medicaid and typically are only in one state, they have no choice but to accept that rate. And they hope they can survive until times get better.

Other commercial plans that are in many states can and often do leave the state, and then there's a lot of disruption in the care for people when plans leave.

So what ACAP has suggested -- we do have federal legislation, which is great, and we're thankful for that. But we have asked CMS to have more transparency in the rate-setting process. We'd like the state to be able to share the data and the assumptions and the trends that built the rate so that our plans can understand why they're getting paid what they're getting paid, and also ask for greater oversight at the federal level of the rate-setting process, and also looking for a way for our

plans to challenge the rates without having to go to court. Especially for plans like ours that have one client, the state, going to court is not really a very wise decision on their part. We'd like to have an administrative channel within CMS to be able to challenge the rates and to have perhaps the CMS actuaries opine on the rates.

So a lot of these other challenges really all stem from the lack of actuarial soundness. The one that doesn't necessarily is churning, and I don't know if you all have talked much about churning here, but people go on and off the Medicaid rolls all the time even though they are still eligible for Medicaid. We did some research that showed that the average Medicaid enrollee is on for about 78 percent for the year, and for an adult it's actually only 68 percent a year. But these are people who they fall off, they're still really eligible, they just didn't get the postcard to remind them to get on, or they got it and they couldn't get transportation or they couldn't get a baby-sitter or they couldn't take off from work, and they end up coming back on.

About half of the people in some of our plans come back on the rolls after three months. And so this constant going on and off is not good for the beneficiary. They find out typically that they're not eligible when they go to the CVS and say, "I want to fill my asthma medication," and they say, "Well, you're not eligible." Or they have an event that lands them in the emergency room. It's not good for our plans because our plans are making investment in well care, and they need the time to pay off that investment. So ACAP has called for states to be allowed to have people on Medicaid for 12 months. Right now states can have children on the rolls for 12 months before they have to re-enroll, and about half the states do. But we believe that allowing adults to be on for 12 months would improve the quality of care that they receive and make it more sustainable for the Medicaid managed care plans.

Later on, we may talk about the interaction between the exchange and Medicaid, and this issue is also very important there because people will be churning back and forth between Medicaid

and the exchange as well, and there's a lot of administrative and care coordination issues related to that.

But going back to the issue with the actuarial soundness, that impacts our ability to maintain our networks. As you know, providers don't want to take Medicaid or they limit the number of Medicaid beneficiaries, and that's all related to the rates. Our plans have really significant IT challenges ahead of them. There's a requirement for changing the whole claims payment system to ICD-10. That's not being paid for by the states. So those are all really related to the rate setting, one of the big issues for our plans.

The last one I will leave you with is kind of the great unknown about the exchange, and all of our plans -- people always ask me, "Are your plans going to get into the exchange?" And they all want to get in. But it's a big lift for them, especially our plans that only do Medicaid, and one of the issues for them is the need to have the reserves and also to be accredited. And so maybe you'll want to talk about that later, but that is certainly a very big challenge for our plans in terms of making the decision and then trying to pull it off.

CHAIR ROWLAND: Thank you.

And now I think we'll hear from a plan on the ground, from Mark. We need to be cognizant of the fact that our time is limited.

* MR. REYNOLDS: Okay. I'll try to be quick.

My name is Mark Reynolds, CEO of a community health center, FQHC-based health plan in Rhode Island. We serve about two-thirds of the people enrolled in Medicaid managed care in Rhode Island, and that also is about half of the total Medicaid enrollment in Rhode Island. We serve, in addition to the TANF population, also children with disabilities and adults with disabilities, including all of the state's children who are in foster care or substitute care of any form.

I'd like you to think about managed care as a spectrum. There are various forms of

managed care, and managed care has often been demonized, as you know, and certainly some of that has been due to some aggressive profit-seeking practices on the part of some health plans. But it is also true that managed care provides a way for there to be a focus on prioritizing access and quality of care.

And, in fact, if you look around, you'll notice that principles of managed care have really begun to permeate all other insurance and care delivery forms. So there really has been a lot of learning from managed care, which has now permeated much more broadly beyond HMOs, beyond Medicaid managed care organizations -- managed care organizations in general.

We really believe that federal policy should be less focused on sort of is managed care good or bad, but really how can the federal government help states become smart purchasers of managed services, because in practice we really are all talking about how services for people can be better managed. Whether they be managed at a provider level or managed at a higher level, there needs to be coordination of care, there needs to be coordination of services. And that's exactly what managed care does. And success or failure in managed care is primarily a function of the obligations placed upon the organizations managing that care.

So what obligations does the state place upon a managed care organization? How does it oversee those obligations? And what incentives are provided as part of those obligations to achieve the right outcomes? And I think there are a great deal of stories of great success in Medicaid managed care, and a lot of that really accrues originally to the management at the state level.

And we believe also -- at least I believe certainly that managed care is often very crucial -- managed care organizations are crucial to the operation of Medicaid in many states. Medicaid managed care organizations end up being partners with states in order to figure out a way to deliver quality care and better access in a way that is affordable. And that's really what Medicaid managed

care is about. And Medicaid managed care organizations are able to work with a number of providers across a large geography, and at the same time, they're able to offer a unique level of flexibility and support for state Medicaid organizations.

I've worked in two different state Medicaid organizations. In both cases, particularly more so in one than the other, we were rather strapped in terms of administrative resources. It was very hard to get things done. We were strapped both in terms of the financial resources we were offered, but also in terms of all of the rules of government--the rules related to hiring, contracting, flexibility in contracting, network development, pricing in terms of rates.

Because state Medicaid agencies are part of a much larger state organization, a state bureaucracy, they must adhere to and follow all of those rules that have been established statewide, and that means there's not that much flexibility for states, nor are there the resources to really be creative often and to pilot new approaches.

Medicaid managed care organizations provide exactly that for Medicaid administrators. They're there as their partner. They're able to do some things very flexibly in terms of service development, in terms of quality incentives to be built in for providers, in terms of rates for providers, which are very hard to accomplish if you're doing it on your own as a Medicaid administrator.

I'll try to give to examples, the work we've done recently. The first really is about program innovation, and people don't talk about this much in terms of managed care. People see managed care as generally about financial controls, sometimes about care management and care coordination, but I'd like to add to that the work that we've done on developing new services.

When we, Neighborhood Health Plan of Rhode Island, took over care for the children with special needs in Rhode Island, there really was a dearth of services available to children with behavioral health needs. Effectively, children had outpatient care available to them and inpatient

care available to them, so they could go into the hospital, and there was very little in between.

Over time, we have developed a series of unique and different services designed to meet the needs of children who aren't all the same and who do need different services as alternatives to hospitalization, either as diversionary services, services when a child has an acute crisis that they can go into that service and avoid a hospitalization, or as a step-down placement so that they move from a hospital placement to an alternative setting. And we have developed on this graph -- the two dark items are the prior services before we became involved in the program, and the other lighter green items are the new services we've developed over time in order to serve as alternatives. And we did that by working with providers that already existed, but who with us wanted to partner and figure out how to do something different. And it took a partnership. It took them taking a bit of risk to be willing to develop a service and hope that the volume would be there to be able to cover their costs. And it took us taking a risk to be able to develop new pricing which would make that risk a viable risk for that provider. And that is something that would have been very hard, frankly, for the state to do on its own because of the way we're able to partner with providers as well as the state.

Over time we have been able to -- we were able to reduce the number of inpatient behavioral health days for children by 25 percent. We've been able to sustain that over a five-year period. That has also resulted in a drop of 20 percent in terms of the cost of children's behavioral health services, which we've also sustained over a five-year period, which is rather remarkable in the current period of medical inflation.

And all of that has delivered much better care for those children. A child ending up in a long-term inpatient hospital stay for a behavioral health reason is really a lousy place for a child to be, and this is a much better outcome.

We've done some other work recently which has focused more on our adult disabled

population. Last year -- just over a year ago, we put together a Transitions of Care program, largely based on Eric Coleman's Transition of Care model, although we modified it. We tried telephonic care management, although we are now expanding it to include in-person care management.

We focused really, again, on those care transitions, when people are in a setting such as an institutional setting, in a hospital, what happens to them when they move out of that setting. Can we find a way of making sure that they don't just go back into the hospital setting rather immediately. How do we connect with those people, make sure they understand their discharge information, and make sure that they understand their medication, connect with their primary care provider, and how do we coach them to make sure that they understand their own needs and know how to follow up for themselves on what they need.

And this program has been quite successful for us. We have been able to reduce our readmissions for our adult disabled population by 13 percent, at least the 90-day readmission figure by 13 percent over a 12-month introduction in this program. We have had a reduction by 20 percent in ER visits during that first 90 days, and also increased, by a smaller amount, but about five percent the doctors' appointments for this population.

We're ow moving to, again, build this as an in-person contact and we hope to be able to expand the success of this program.

In general, I would encourage MACPAC to find ways of encouraging States to look at greater employment of managed care programs and managed care techniques in order to serve these populations that most need care coordination, that most need additional access, and that most need new service development. Those are people who are disabled and people with long-term care needs, and particularly people who are dually eligible, and I believe that MACPAC could be able to be on record as sort of pushing States to be able to move in this direction. I think for a variety of reasons, States are quite shy of moving in this direction, and often that shyness comes primarily

from pressure back from providers, but also sometimes by constituents.

Also, certainly as Meg had pointed out, actuarially sound rates are important to making sure that the work that we do is quality work. The one reason managed care is able to have broader networks of care than fee-for-service Medicaid, and that is typically true in almost every State, is because managed care organizations tend to pay better provider rates than fee-for-service Medicaid. And the only way we can sustain that is by making sure that the pricing is actuarially sound.

And finally, we definitely believe that continuous Medicaid eligibility is critical to preventing the churn of populations, to make sure that they stay enrolled, to make sure that we really can have a long-term effect upon their clinical care needs. And again, that will be, as Meg said, much more important even when the exchange is put into place so that those two programs can work seamlessly together and not leave people falling through the gaps.

CHAIR ROWLAND: Great. Thank you very much.

Candy?

MS. SCHALLER: Thank you. I don't know how to find my slides.

[Laughter.]

* MS. SCHALLER: We really appreciate the opportunity to be here. The first slide is just a quick sort of profile of the trend towards Medicaid managed care, which I know you're all very well aware of. I'm sure a number of you remember when Medicaid managed care was a sort of aspiration, where there were very few States that took advantage of what health plans could bring to Medicaid beneficiaries. Now, almost half of Medicaid beneficiaries are in full-risk Medicaid health plans, and those plans span a variety of different plan types.

As you can see, the enrollment is fairly evenly split between these different plan types -- sorry -- and AHIP actually represents this broad spectrum of organizations. We represent almost 80 organizations that provide services to Medicaid beneficiaries. This covers about 75 percent of

all enrollees in Medicaid health plans. As you can see, it spans health plans that solely focus on Medicaid, those that focus on a variety of products in the private sector, as well as the public sector, both single-State and multi-State, for-profit and not-for-profit.

What we find striking is that the sort of community of interest types of issues and challenges that we hear from our plans are really very consistent across these different organization types, and you will see that our issues are also very consistent with those that you have heard from Meg and Mark.

This slide just really reflects sort of the key reasons that Medicaid health plans are serving so many beneficiaries. And again, I think they echo themes that you have already heard, the type of care management, of patient-centered coordination that plans are able to bring, multi-disciplinary care teams, promoting care that is with a primary care provider rather than in the emergency room, outside of institutions rather than inside where the beneficiary is interested in that option, quality improvement activities and projects that they engage in on an ongoing basis, pushing out information to providers about their performance, sharing best practices, sharing other types of information about current care practices, beneficiary information and outreach and education, for example, education for asthmatics to allow them to stay out of the emergency room, which improves quality of life as well as obviously their clinical progress, promoting access to care through provider networks, linkages to community services -- housing, food assistance, other services that really enhance the opportunity for beneficiaries to benefit from the medical services that the plans provide, and they offer greater budget predictability to the States. Rather than dealing with individual providers, dealing with the plans on a capitated basis has a single focal point for responsibility that has been beneficial to the States and is one reason that States are looking, even increasingly now, to health plans to take care of their beneficiaries.

And this is just a quick list of some of the near-term opportunities and challenges that our

plans are identifying. And again, I think you'll see very similar themes to those that you've heard from Meg and Mark and that will be echoed in some of the issues that Mike raises in a moment. But certainly the State fiscal crises are, I think, coloring everyone's view of Medicaid programs, and the significant challenges that the States face obviously also present challenges for the plans, how to do more with less, how to make State Medicaid dollars as valuable as possible to the beneficiaries who need the services that the plans and the States are focused on providing to them.

There is a lot of interest, we know, around the country, certainly in town and we know among yourselves, about dually-eligible beneficiaries and how best to address their needs, how to make health plans more available to dually-eligible beneficiaries, and certainly the longstanding challenges of integrating the Medicare and Medicaid programs is something that has been, I think, in the forefront of the minds of people working in certainly Medicaid health plans and the Medicare program for an extremely long time, and it is very comforting, I think, in a way, or certainly promising, to see the increasing attention that this is gaining.

But the problems or challenges are still the same as they have always been, how to take two benefit packages and meld them, how to take payment streams and meld them, how to take oversight between States and the Federal Government and meld that oversight so that it provides some better coordination between the programs, better opportunities for plans to participate and some efficiencies, and most importantly, really allows the seamlessness of benefits to be something that beneficiaries don't have to worry about and where they don't see disconnects between the programs or any sort of lack of clear integration. So those are issues certainly that our plans are thinking hard about, and as I say, we know you are and we look forward to further dialogue around those issues.

Managed long-term care obviously is another area. Again, I think it presents opportunities for States and plans and beneficiaries. But as Meg highlighted, our plans, too, understand that as

you increase the availability of Medicaid health plans for these populations, there are some very special issues that you need to be concerned about, needing to know who the traditional providers are that are already seeing these beneficiaries and being able to work with them, working with other providers of care and services that are, again, already linked with these beneficiaries so that those services can continue in a seamless way so that beneficiaries can be comfortable, working with beneficiary groups and stakeholders on the front end as programs expand or are implemented to ensure that there is the right sort of dialogue.

Clearly, our plans are also concerned about actuarially-sound rates. Having adequate payment is essential to the plans being able to provide the services and programs that beneficiaries benefit from.

Scope of coverage gets to not only the difficult choices plans may need to make with regard to benefits, but also issues of carving in and carving out services and how they affect coordination for beneficiaries, but also the opportunity, again, for plans to provide the sort of value-added types of services and programs that beneficiaries rely on.

And finally, obviously, there is a huge emphasis now on health care system change overall, lot of attention on ACOs, health homes. Plans have done many of these things over a long period of time in one form or another and are very interested in being part of the work that is ongoing.

Finally, just to mention briefly some longer-term issues, plans are also very interested, our plans, in looking at Medicaid in the exchange. As Meg highlighted, plans that are Medicaid-focused are very much looking towards what opportunities there may be to serve beneficiaries in the exchange, and our plans overall in the Medicaid space are equally concerned about how beneficiaries move back and forth between these programs, not only for the newly-eligible adults, but in terms of any impact on family coverage and coordination there that may be important.

Again, obviously, Medicaid expansion provides a lot of opportunity. There is a lot of

debate about how the expansion can or will move forward, something that our plans are very interested and engaged in.

There is another issue that obviously could very much impact them which is the premium tax or the annual insurance fee. This has sort of broad -- raises broad concerns about the impact on consumers and their costs, but for the Medicaid plans, obviously, it's a very special and sort of different issue that, again, impacts the availability of dollars to do what everyone believes is their first priority, which is really taking care of their members. To the extent that the fee places even greater challenges on the dollars that can flow from the State to the plans only for the purpose of actually doing their job under the State program, this is obviously a significant concern.

And we are also looking at the implications of the primary care reimbursement increase to Medicare rates. Obviously, it is important that providers be appropriately compensated and reimbursed. As Meg said, that is something that the plan -- and Mark -- that is something the plans do and want to be able to pay appropriately. So I think this is fundamentally somewhat of a good thing. There are questions about how States' health plans are accountable for and link into their rate setting, this reimbursement, but also the big question mark, what happens in 2015?

So we look forward to being able to talk further with these issues, and I'll defer to Mike.

CHAIR ROWLAND: Thank you. Mike?

* MR. RASHID: Thank you, Madam Chairwoman and members of the Commission. My name is Michael Rashid and I have been involved in Medicaid managed care for over 30 years, about 33 years now, and I have to tell you, I have never been asked to speak to a Commission like this, so I am so excited that I could pop right now. And because I'm so excited, I have a lot to say, and I'm going to tend to go on for a long time if you don't stop me. In addition to that –

CHAIR ROWLAND: Okay. I'm warned.

MR. RASHID: I'm sure you're ready.

[Laughter.]

MR. RASHID: And in addition to that, I'm the grandson of a preacher, so that also -- so it's in my blood to go on and on --

[Laughter.]

MR. RASHID: -- so I'm very happy that you have my remarks in front of you and I will not be upset if you stop me any time, because I know you have the remarks and I know you will stay up late at night reading those remarks if you do stop me, so I will not be upset, so feel free to do that.

But I just do want to say I am very happy to be here. I am the President and CEO of the Amerihealth Mercy Family of Companies located in Philadelphia. However, we operate in 14 States around the country. We manage care for over seven million Medicaid, CHIP, Medicare, and other insured type people around the country. We have been in this business for about 25 years, again, started in 1983 in Philadelphia.

My remarks will focus on what we call the three As of what we think need to be addressed in any kind of reform of Medicaid. Those three As are accountability, access, and administrative reforms.

Specifically, I'm going to talk about, in Medicaid health plans, the idea of encouraging providers to accept greater accountability for improved health outcomes per dollar of cost. That's the definition that we use for improved value, improved outcomes per dollar of cost.

I will also address access in health care within the Medicaid program, including how health plans manage, measure, and evaluate access to care, and how States monitor and enforce access to care, and the health plan view of what must be done to improve access now and by 2014.

Finally, I'll talk about some of the administrative burdens that we think have to be dealt with in order to have genuine health reform and also to increase the value that the health system is

providing to payers and to patients.

In terms of accountability, everybody agrees that increased provider accountability across the board, broad spectrum of health care delivery is critical to improving quality and lowering costs. We are very happy that the Accountable Care Act will accelerate the adoption of accountable care models. However, as I'm sure you know, payment reform and practice redesign are not enough. Health plans have been implementing global payment arrangements for many, many years.

We have had successes, but also quite a lot of failures in our efforts to implement global payment arrangements. It's not fair, we don't believe, to ask providers to accept accountability for the care, especially financial accountability for the care, if they don't have the full picture in terms of information on the patient in front of them, and that's where we believe that we can come in and add value to any global payment arrangement, accountable care organization, or whatever.

We collect, analyze, and push actionable reports out to providers on the full spectrum of a patient's medical, social, pharmacological, and behavioral background and history. We provide these reports, for example, to emergency room physicians as they are making the decision whether to admit or not to admit a patient.

Another example is that we know that depression is negatively related to a patient's responsiveness to the treatment of diabetes, so we employ case managers to motivate the patients and to make sure that the behavioral health provider and the primary care physician stay in close contact and that the treatment plans are well coordinated.

As you know, Medicaid patients are a resource-intensive population and successful plans like ours will spare no dollars in the effort to coordinate care across all disciplines because we know that helping providers assume accountability effectively is the key to value creation.

In terms of access, we have followed the discussion of this Commission over the months, your meetings and your reports, and we are aware that the Commission -- not only the Commission,

but the resource community as well as the folks at CMS, feel that we don't have timely, accurate, or complete data to allow for an executive evaluation of whether the Medicaid program is providing real access to care for enrollees. We are disheartened to hear that, considering the tremendous amount of data that we submit to the States -- are required to submit to the States, as well as the tremendous amount of data that we collect and the reports that we provide on the subject of access.

I can assure you that regardless of Federal or State requirements, high-performing Medicaid health plans take great effort to ensure appropriate access to care. Quite frankly, full-risk managed care plans have every incentive to ensure appropriate access to care, considering that we bear the risk of costly emergency room visits and hospitalizations that occur when necessary care is delayed because of insufficient access.

I can also assure you that we take a comprehensive view of access. We look far beyond the raw number of contracted providers by type. We also monitor whether our providers are geographically accessible to our members, including those who rely on public transportation, how many are accepting new patients, whether our contractual standards for availability, urgent, routine, or well visit appointments are being met, and whether the network represents the cultural and ethnic diversity of our members.

We measure our performance related to access to care through routine audits of our providers, monitoring of our physician-to-patient ratios, patient surveys, and geo access reports.

Perhaps more importantly, however, we look at the care that is actually being delivered. We identify primary care practices that have lower-than-expected rates of routine well visits. Practices that meet our performance expectations receive premium compensation arrangements and consistent underperformers may ultimately be terminated from our network.

We also closely monitor our HEDIS and CAHPS results on access to care measures to ensure that our members are getting the care that they need. The data that we collect and analyze

related to access is routinely reported to our State regulators. The Pennsylvania Department of Public Welfare is particularly sophisticated in this regard. I know that Mike Nardone, former Secretary of the Pennsylvania DPW, came and spoke to you this past October. Our regulators in Pennsylvania require us to report routinely on every aspect of access to care, and as I mentioned earlier, on an ad hoc basis, when a significant change in the composition of our provider network is contemplated, they also come in and do audits.

I'd like to make one final point related to access, which I think was mentioned earlier. Because health plans are not locked into State fee-for-service schedules, we can be much more flexible in our payment and contracting arrangements, and therefore, we are able to pay more than the Medicaid fee-for-service schedule dictates when the market requires that. That is especially the case in rural areas for physician and hospital services and also for dental services. In Pennsylvania specifically, in the rural areas, dentistry, it was almost nonexistent in the Medicaid fee-for-service area. We went in and we were able to build a network, but we had to pay almost twice what Medicaid provides, but we were able to get it done.

As a health plan, we are very concerned about the capacity of the health system to accommodate the projected increases in the number of insured individuals. At the current graduation and training rates, the nation could face a shortage of as many as 150,000 doctors in the next 15 years, according to the Association of American Medical Colleges. The U.S. has 352,000 primary care physicians now and the College estimates that there will be 45,000 more needed by 2020. All parts of the health care system need to work together to expand the number of primary care physicians, increase the scope of practice for other health professionals, and ensure appropriate access to specialty care for low-income populations.

Where permitted by State law, the Amerihealth Mercy Family of Companies contracts extensively with certified Registered Nurse Practitioners to serve our Medicaid members. We

support efforts to expand the scope of practice for other health professionals, such as pharmacists and dental professionals.

In our more rural markets, our creative contracting models and efforts to minimize administrative burdens have increased participation from specialists, who are generally unwilling to see Medicaid fee-for-service patients.

In terms of administrative reforms, our last "A," the plans and the States are required to generate tons of data now, and the meaningful use of that data, as you have remarked in some of your reports, the meaningful use of some of that data is questionable. Health reform with its many new regulations will only increase the demands for data. Concerted efforts with plan involvement should occur to ensure that data is useful and it is value driven.

An equally important element of administrative simplification relates to the barriers that plans have to coordinating care for the dual eligibles. This high-cost and very vulnerable group would benefit greatly from the coordination and accountability that health plans can provide. Different Medicare and Medicare rules, however, make coordination for this group only possible within the vehicles of SNP plans or PACE plans, and enrollment in those plans is very limited due, to some extent, regulatory reasons.

In closing, we view the Accountable Care Act and health care reform at the State level as paving the way for a whole new level of partnership between providers and health plans. Concepts like payment reform and practice redesign alone, however, are not enough. We all need to identify what each do best and incorporate those strengths into an accessible, sustainable, and data-driven health care system for all Americans. Thank you.

CHAIR ROWLAND: Thank you, and thank you to the entire panel for some opening remarks that will begin our discussion. If any of the Commission members have questions to pose to the panel, please let me know. Patty and then Mark.

DR. GAYNOR: Thank you. I have two sets of questions. I think you raised, a number of you raised the issue that by being plans, you have provided States with flexibility and administrative coordination services which they would not possibly be able to do. Have any of you put a price on what that represents to the State in terms of the components that you are adding that they would have to try to replicate if you weren't there? Maybe elaborate a little bit more on the flexibility that you are giving States, because this whole issue about do States have adequate flexibility would be useful.

My second question is the flip side. Could you discuss the regulatory burdens that you believe are placed on you, or maybe give examples of those that are most onerous that impose both financial and flexibility inhibitions on you, sort of two sides of the same issue.

MR. REYNOLDS: I am going to jump in. I will do those in the inverse. I actually don't find our current regulation to be particularly onerous, just there are occasions when we are asked, for instance, to build a service into a plan and then the State tells us we have to -- we can't change the purchasing arrangements or the pricing, and that is bad. Like, why is it in the plan if we can't? But that's rare. I think the bigger issue is really looking toward managing people who are dually eligible and having two different programs with two different sets of regulations.

So in my experience, our regulations have not been onerous, not that they are always right, but that overall, certainly that has not been the problem. It really is having two different programs with two different sets of regulations that becomes a bigger problem.

In terms of flexibility for States, we haven't priced it. That would be an interesting conversation to have. But to give a little more meat on the bones, again, the example that I used before where we developed new behavioral health services, I think the State of Rhode Island would have had a very difficult time doing that, and they would have had a difficult time in part because of contracting rules at the State level.

When the State contracts for a new service, they would have to develop a new service, have it very well specified. They would have to go through a very public bidding process, both the department that manages it would need to sort of make a series of rules. They would have to get the Department of Administration to approve it. It would be a long, drawn-out process.

Instead, because it is part of the coverage that we have, we were able to reach out really to a limited set of providers that were interested in stepping into the unknown. Now, they still provided potential coverage for the geography we serve, so we didn't violate any issue of Statewideness, as an example, but we didn't have to really try to get out there, either on a political side or a regulatory side, and sort of make sure we were serving any provider that wanted to step in the door -- not that we wouldn't have taken more providers, but we weren't under the -- what really becomes almost a political obligation to act in a certain way.

So we were able to find providers that were willing to step into the unknown and take a risk with us on creating a new service, and we are able to do that in a successful manner. And if it failed, we would have been able to close up that pilot and move on and try something new in a way that States seem never to be able to do. They tend to create new services and the services stay forever. You know, once you've reached that burden of actually creating the regulatory environment, the rate structure, the political sets of arguments, sort of which service should be where, you create a whole new constituency of providers that are getting paid this new service and you can't draw it back.

So it is both true on creating new services and modifying services that there's a level of flexibility that happens because our action is private action, not public action, and that's just one of the many examples, really.

MR. RASHID: I would echo what Mark is saying. The biggest administrative burden for us has to do with the dual eligibles. It's an opportunity, but it's a burden right now, and that is

because we can't really serve the dual eligibles the way the program is set up now.

I don't want to leave the impression that generating data to the States is an administrative burden because we know that's to be expected to happen. So we don't have a problem generating the data. But if the data is not being used, it's a waste to everybody.

In terms of the actual cost of providing services over and above Medicaid fee-for-service, I don't know that I could give you a number for our whole program, but for specific areas, like dental, we could give you a number, and I think of one hospital in Philadelphia, Children's Hospital of Philadelphia, which did not contract with any other HMO except ours. We had to pay -- we ended up having to pay them in order to keep them in the network, a very important hospital in Philadelphia, I think you all would realize that. Over 200 percent are Medicaid, and I could give you what that actually ended up being in terms of millions of dollars, if you are interested, that we had to pay, and the State knew it and the State appreciated the fact that we were the only HMO that had CHOP in our network.

CHAIR ROWLAND: That is great. Mark, you had a question?

COMMISSIONER HOYT: A question maybe primarily for Mark or Mike, although anybody can respond. I heard the concerns loud and clear about money, fiscal stress. So Rhode Island has a highly publicized global waiver. I don't think that Mr. Alexander got block grants in the end, but there are certainly a lot of savings being touted behind the waiver. Alexander has now moved to Pennsylvania to be the Secretary of Public Welfare. So I wondered if you could just comment about maybe even how the communications around the waiver, misunderstandings perhaps, or what it's felt like in Rhode Island where it's being implemented or concerns you would have, Mike, on Pennsylvania, because I know he's talking about doing the same thing there.

MR. REYNOLDS: I'm sure whatever I say is going to be highly charged politically, but at some level, I would say the discussion over the waiver has always been overblown from people

holding the position both on the left and the right. The waiver in Rhode Island was largely viewed at the State level as a practical set of issues, not an ideological set of issues, and what this waiver actually offered Rhode Island was a significant increase in Federal reimbursement through finding new Federal reimbursement for dollars that were previously expended at full State expense, what's otherwise known as CNOM, costs not otherwise matchable, and that was the great advantage to Rhode Island, more than anything else, more than the rest of the waiver.

It was also true in the calculations that Rhode Island believed that it had no risk of reaching the global ceiling associated with the waiver during that period, so while there was a theoretical worry about a block grant-like waiver, a globally capped waiver, it in Rhode Island terms was considered theoretical as opposed to practical. And so with a practical lens, that wasn't a worry. It may still be a worry from an ideological standpoint, but not from a practical standpoint.

The other thing the waiver provided Rhode Island, although Rhode Island has struggled to take advantage of this, is a little more flexibility in the approval process for modifications of its multitude of waivers. By moving all of the waivers under one umbrella, establishing fixed time lines for those approval processes, it at least laid out a more consistent architecture for requesting changes, although in the process it actually made making some changes harder than they had been before because it moved elements that had been controlled solely by the State plan into a waiver approval process.

So it has been a mixed bag in many ways. It has not either been sort of a death knell to constituent interests nor has it been a fundamental shifting in the landscape of how Medicaid is managed with total flexibility at the State level. So in that sense, I believe that the Rhode Island waiver has received much more attention from both the left and right than is appropriate.

MR. RASHID: We have met with Secretary Alexander and talked about it briefly. It's still at a very high, high level, and I'm not the expert on things like that, but there seem to be positive

and negative arguments on both sides. I believe the devil is going to be in the details in terms of how these things are worked out, how maintenance of effort is going to be worked out, and we are going to -- obviously, the stakes are huge and we're going to watch it very closely.

CHAIR ROWLAND: Richard?

COMMISSIONER CHAMBERS: You heard from the presentation by staff that we are still early stages of formulating positions on managed care, particularly from the perspective of access to services for Medicaid beneficiaries. A couple of things that were said, your observations to help us in our thinking, is that from your map, Meg, is you can see at least from ACAP's members when you look at it, it's pretty clear where the plans are in the country. So how do we think about, is in managed care, where there's places in the country where it doesn't exist or hasn't existed or hasn't been able to or something, your thoughts, anyone on the panel, in that perspective.

And then the other piece is as we get back to that basic question about support or non-support of managed care, philosophical ideas, is that for every plan like yourself, you know, Mark, a neighboring health plan that is nationally and regionally recognized for performance and quality and cost effectiveness, there's other experiences of bad experiences with managed care. Robin Smith could certainly tell you about her experiences in South Carolina with her special needs child and the struggles she had with the managed care plan that they implemented in South Carolina.

So the second part of that is just that how do you -- what is it that we -- what should staff be looking at as to are there elements of managed care that should be used as benchmarks, that should be for any kinds of policy formulation of what's good and what's bad, or what elements should be there? So if anyone would like to take either parts of that –

MS. MURRAY: I'll take a stab at two of the pieces of that. One, we have been surprised this year so many States are looking at managed care that we never thought would look at it before. Louisiana just put out their RFP to do managed care. Arkansas, Montana, States that we never

would have thought of are doing managed care. So it really is, I think, States are looking at it as a solution to both their cost issues as well as their quality issues. So I think that that map will be filled in over time.

But in terms of the issues with monitoring the quality, we believe that that's really fundamental, and one of the things that has made such a difference in managed care is that we can measure it, and we have the HEDIS scores, which are not perfect, but it's a way of monitoring the plans. We know that Mark's plan, I think, was, what, the number -- second plan in the country in terms of its quality?

MR. REYNOLDS: Well, we're seventh now, but --

MS. MURRAY: Okay. Sorry.

[Laughter.]

MR. REYNOLDS: [Off microphone.] -- first one.

MS. MURRAY: He was the first one, so that's what I'm remembering. Anyway, but the importance of managed care is that we can measure it, but we can't in fee-for-service, and that's another thing I'd like to leave the Commission with, that a lot of the requirements that managed care plans are appropriately held to, and I think our plans would agree that they probably could be even higher, but there's nothing in fee-for-service in many States and nothing in PCCM. They don't measure quality. So we don't know about the access. Our plans are held to access standards of you have to have, you know, one PCP for so many kids or geographic standards. There are no standards like that in the fee-for-service program and no quality standards.

So I think that the important thing is to always be aware of what we're comparing it to, and we think that our plans do very well. We know that the ACAP plans in particular, safety net plans, on average, do have higher scores, HEDIS and quality scores than non-ACAP plans, but we can't even measure that against fee-for-service because there's no requirement to measure the quality in

that sphere, so --

VICE CHAIR SUNDWALL: Can I ask a question?

CHAIR ROWLAND: David?

VICE CHAIR SUNDWALL: I want to thank the panel. This was very informative, and I think as you've heard, we really are looking for best practices, what we can do in managed care that would be worth recommending.

One thing I was curious about, you both in your -- at least a couple of you mentioned in your comments you are anxious that, as a policy matter, that you be able to participate in the health insurance changes. Now, Utah, where I am from, is one of the only two States that has an up and running health insurance exchange, and the way we have done ours is we don't do Medicaid eligibility. We link to it, but it remains a government function, not a function of the exchange. But it's still a marketplace for people to purchase insurance. So I'm just curious to understand better from you, as you understand the exchanges, do you see that as the only place where one can get -- I mean, will they be required to get insurance, and that would include Medicaid or managed care plans?

MS. SCHALLER: Well, I think our plans are doing a lot of thinking about this and thinking about different ways that it might be worked out. Certainly, I think as Medicaid health plans think about being offered through an exchange where there are broader populations, obviously, where they don't currently focus, that's a pretty daunting idea and they're really, I think, trying to see if there are some creative ways that they can be directly involved in caring for certainly the beneficiaries that may be subsidy-eligible, but in some cases, I think they really feel that their focus is more on beneficiaries up to 200 percent of the poverty level.

In the basic health plan, it's an idea that for some States that already have similar programs, may be an attractive mechanism, but it seems that other States are also looking at that possibility,

and I think the concern is overall, as we have highlighted, that the plans that do serve those populations, the low-income populations, are plans that really understand that, that have providers in the places where they live, that have programs that are specifically focused on their needs.

So I think this is all still in sort of fairly early stages, and certainly you can imagine that there may be some sort of broader interest in other organizations that don't currently serve these populations. But I think the ones that do serve them are very concerned about how this is all going to flow.

VICE CHAIR SUNDWALL: One last question, if I can, Mark, before you ask a question, is what can MACPAC do for you to achieve what you call actuarial fairness or soundness? How do you see the MACPAC as -- because States set the rates, correct? What would you seek from MACPAC as far as actuarial soundness?

MS. MURRAY: I think one of the things that ACAP would like to see, as we said, we have it in statute, which is wonderful, but it's not always enforced. And so what we would like is for MACPAC to take up some of the things that we have suggested, which is one that the rate-setting process should be transparent so that the plans know the assumptions that the States are making when they set the rates. That way, if they say, well, pharmacy costs are going to grow by two percent, our plans can say, well, where did you come up with that number? That is not realistic.

And also, then, to have this administrative channel where we can go to CMS to challenge the rates. So those are two of the things that we would like to see MACPAC endorse.

MS. SCHALLER: We've made similar recommendations. I mean, we really think that it's important for the plans to have sufficient information that they can replicate the States' rate-setting process, where the rates are set administratively in order to have the right sort of dialogue around how the rates are set. People on both sides of the table need enough information to be able to do that.

I think they're also very interested in being engaged with the State early on in the rate-setting process, again, because there are difficult decisions that need to be made, and the way those decisions can get made, I think, that will be to everyone's benefit, can be very much informed by having an early dialogue about how to best use the limited resources available.

CHAIR ROWLAND: And now we'll turn to our actuary to ask a question.

COMMISSIONER HOYT: I'll just stay on the same theme. You say you have concerns currently. Do you have any thoughts about a methodology or an approach you'd like to see followed as we prepare to add 16, 18, 20 million people to Medicaid? They probably won't all be in managed care, but assume 72 percent or whatever the current figure is. What kind of thoughts do you have about what you'd like to see happen there?

MR. RASHID: Well, just let me -- David, thank you for your question. That's an extremely important question. Are you all accepting comments later, because I know our actuaries have some thoughts on that --

VICE CHAIR SUNDWALL: Now or never.

[Laughter.]

CHAIR ROWLAND: No. We are glad to receive your comments. Thank you.

MR. RASHID: And they also have some thoughts on yours, Mark. I can't tell you what they are, but that's an extremely important question about these new populations. Not a lot of data --

MS. MURRAY: And I think that's the big issue. What does this new population look like? I was speculating they look more like the SSI population than the TANF population, but we don't know that. So I think one of the issues would be making the rate setting -- perhaps having risk corridors so that the plans aren't making a huge profit if it turns out they look more like TANF than SSI, but not taking a huge loss might be one of the things that the plans would want --

CHAIR ROWLAND: They might not look like either population.

MS. MURRAY: Or maybe not. Yes. We don't know. We don't know.

MS. SCHALLER: Yes. I think our plans share that same issue, you know, exactly who are these folks, what would you expect. I mean, many of these individuals may be people, again, who don't have a lot of experience seeking care on any sort of regular basis. So how they begin to do that and how they begin to sort of stabilize in the health care system is an open question.

MR. RASHID: We did manage a -- and still manage a population of uninsured people, 10,000 in Indiana, the Healthy Indiana program, and that program has lost money for four years for us. We're still in there, though, and it's getting better, but we had no idea of what the utilization was. But we do have some data now and we will submit the Commission some data based on our experience with those people.

CHAIR ROWLAND: Okay, great. Let me ask another question. One of the concerns that we are supposed to address is looking at access and access barriers and early warning systems about where there are access to care issues. From your experience as plans, is there information or data that you would say would trigger an alert that there is a distribution problem or an access problem going on?

Can you -- now, I know that some of the emergency room physicians have said, when we start to see a certain profile of patients coming in, we know that there is some gap going on out there in the delivery system. So as we are trying to look at streams of information that could be real-time and useful to identify where there are access problems, are there things that plans would be picking up or that you would be picking up from your own provider networks about gaps in coverage?

MR. REYNOLDS: We rely a lot on looking at appeals activity complaints, which is also then available upstream to the State for regulatory purposes. We also rely even more heavily on

member committees that we have for each of our lines of business, so that we have members that -- sometimes it's the parent of the member, if they are children, but sitting on committees, meeting regularly, identifying issues that they have seen in their experience and then trying to make sure we work that through our system to follow up on that work. I don't know that that would be necessarily a vehicle for a regulatory view in, but we -- in other words, though, both through those member committees and through appeals activity or complaint activity, we tend to rely more on the member voice than the provider voice in identifying those access issues.

CHAIR ROWLAND: Do you do any beneficiary surveys, ongoing satisfaction surveys?

MR. REYNOLDS: We do. We do two surveys, one, the CAHPS survey, which is, you know, the national standard, and we also employ and utilize in certain providers a site-based survey which is similar to CAHPS but designed to be more site-oriented and allows us to drive really the "n" up for those survey sites.

I would say the one problem with CAHPS overall is that -- one of the good things about it and the bad thing about it is it's really mostly not a survey of the health plan, but a survey of the providers, and that's a good thing at a certain level because that's where care is provided. But it's actually not a particularly great tool to measure health plan performance. There are a few questions which are about health plan performance, but I do think that that's one area of needed development in the CAHPS arena, to really understand how a member, how a family views their experience being supported by the health plan, not just by the providers that are part of that health plan's network.

CHAIR ROWLAND: And whether the nurse answering the call is in Florida or South Carolina, right?

MR. REYNOLDS: Yes.

MS. MURRAY: Some of our plans also do their own "secret shopper," where they call around to providers to see, are they really accepting patients. They also monitor the

auto-assignment rates. Beneficiaries are supposed to pick a primary care provider, but a lot of them don't, and if that number is going up for some reason, those are the kinds of things that are internal to plan, but that they do monitor.

CHAIR ROWLAND: It will be very helpful to us if, as you go back and reflect and want to submit additional comments, if you could really give us some ideas about some of the other ways we might recommend that we look at things.

And I want to thank you for joining us today. I know we will continue to work with you and to get your comments, and that you will be very interested in the work we do on managed care. So thank you for your time and for the advice you've offered to us.

Next we're going to call on Michelle Herman from the Commission staff and Jennifer Edwards to the table to really review with us the results of MACPAC's survey of the states' methods for examining access to care so that we have a perspective from the state level how managed care is being evaluated and monitored. Jennifer Edwards is a principal analyst with Health Management Associates, who helped conduct this study for us.

Welcome, Michelle.

**#### MACPAC'S SURVEY OF STATES' METHODS FOR EXAMINING ACCESS TO CARE: PRELIMINARY FINDINGS**

* MS. HERMAN: Thank you. Good afternoon. My name is Michelle Herman, and I would like to introduce Jennifer Edwards from Health Management Associates, who we contracted with to help us conduct this survey.

Our presentation will describe MACPAC's first survey of state Medicaid directors, which we created to collect initial and timely information about how states monitor and identify problems with access to care and provider capacity in Medicaid and CHIP.

The Commission is charged with examining access to care and services for Medicaid and CHIP enrollees. In MACPAC's March 2011 report, which was just released in March, the Commission described an initial framework for examining access to care that takes into account several elements, including unique characteristics of Medicaid and CHIP enrollees, provider availability, utilization of services, and program variability across states.

Consistent with the Commission's charge and the framework described in the March report, the survey asks states to report on access, to ask states about ways in which they monitor provider availability, and other indicators of access, including how they report based on their existing systems.

The survey has several goals. First and foremost was to learn from state Medicaid directors about how they and how their programs monitor and address access problems. Also, this survey advances the Commission's initial efforts to fulfill its charge to examine access, to examine also issues related to Medicaid managed care, and also to inform in the development of a early warning system, which the Commission is statutorily charged to address and develop, which will help to identify provider shortage areas and other factors that may affect access to care.

Also, the survey builds an information base of existing state activities upon which the Commission can base future work on what states are currently doing. And, lastly, it also identifies several differences between how states with risk-based Medicaid managed care programs and fee-for-service programs address access.

* MS. EDWARDS: Okay. So let me talk today about the survey. You first heard about the survey when Vernon Smith was here in December. It has just gone into the field then, and so I'm pleased to be here today to give you an update on what we found.

As you may recall, it was developed with HMA and MACPAC staff working closely together to figure out what were the right questions to ask that would get at the issues that were most important to informing your decisionmaking.

We developed a survey instrument with seven open-ended questions, and it's important to think about the fact that they are open ended because people give different kinds of responses to questions that leave it up to them to think about what's most important to them. So rather than being a complete cataloguing of everything states do, this was a chance for states to tell us what they thought was most influential in their ability to monitor access.

Fifty-one Medicaid directors responded to our survey. All 50 states and the District of Columbia did give us a response, which was just terrific, and we appreciate that participation by them.

Some of the responses were in writing and quite lengthy, and some of them were done by phone. And as we began to look at the results, we saw that there was definitely a pattern that states with heavy managed care penetration had really different sort of approaches to monitoring access. So we decided that it was important to report not just the total of 51 responses, but to stratify the responses by managed care penetration. So what we'll talk about is if a state has at least a third of their Medicaid enrollees in managed care, we're going to call those high managed care states. And if they have less than 30 percent all the way down to zero, those are the predominantly fee-for-service states.

So just to give you the top level responses, first just to give you a quick picture of what the survey findings are, we found that all Medicaid directors, no matter what their model of delivery system was, expressed a high degree of confidence that they knew what the access issues were in their states. Though they had a variety of different measurement strategies, they felt as if they would know if there's a problem, and they often do.

The way that they know that is through a range of formal and informal methods. We heard about the phone calls and the data collection, and both of those appeared in the survey results as well. And they ranged from continuous where Medicaid directors would tell us that every day they

know if there's a new problem, to those who monitor some types of data on a quarterly basis or annual.

When we looked back at which states were giving us what kinds of answers, there's definitely a story that you can tell about the delivery systems in these states. And so, you know, frontier states with definite access issues didn't have a lot of data on how bad the problems were in those areas; whereas, you know, heavily concentrated urban populations, a lot of managed care plans in those states, they had much more concrete data to share. So it ran the gamut.

We also found that most states used some form of administrative data, which gave us hope that there would be something to build on for an early warning system. And as we got a little bit deeper into what kind of data that is, we found a tremendous amount of variability, and that there is not a set of uniform measures or data sources across states for assessing access nationally.

So to start first with the questions that asked how do you monitor access, states pair both formal and informal monitoring mechanisms. They look at whether people are using the services that they expect to be needed, and they also look at whether people are telling them that they can't access those services.

All Medicaid directors are in regular communication with a wide network of health care system stakeholders, and we heard about phone calls, letters from advocates, providers, local social service agencies calling, as well as more formal hotlines that many states have created, and times when the Medicaid staff go out and meet with groups of providers.

We also heard about more formal assessments, quantitative measurement initiatives both in managed care, in high managed care and low managed care states. About two-thirds of the states actually do collect HEDIS measures, which does give a pretty good basis for monitoring nationally, as well as CAHPS indicators. The CAHPS survey is more expensive, and so it's not always done as frequently.

About two-thirds of the states are also monitoring -- mining their own claims data for measures of access, and I'll say more about what those are later.

Some of the specific ways that they look at the availability is that they do build in some standards into their managed care contracts, and the managed care plans are expected to measure and monitor against those standards and produce reports, and those may be quarterly, those may be annually in some states. And when there's a problem in that data, either the health plan will flag it for the state, or the state will ask about it, and very often that leads to performance improvement projects.

In fee-for-service states, about ten states told us that they use very specific access standards, but many went on in their answers to describe why access standards have limitations to them and that they really need -- they take a look at a bigger picture rather than just looking for a specific number that describes what would be acceptable access.

The next questions looked at strategies for monitoring provider supply specifically. Again, complaints are a useful source of information about provider supply. They will get calls that say, "I can't find a provider who will meet this specific need that I have," and that was pretty much uniformly the number one answer that states gave about how they know when there's a provider supply problem.

They also put indicators into health plan contracts, things like ratios, number of doctors to a patient, for primary care doctors, specialists, dentists. They look at travel time and difficulty in getting appointments.

They also review administrative data sources to assess availability and utilization of services. They track MMIS quarterly reports on providers. They look at transportation brokers, change in use, and they look for spikes in emergency department utilization in a couple of states.

They also look at provider shortage analyses, and we heard about some of these in one state,

where they compare the number and specialty of participating providers to the total number of practicing physicians in the state, or they compare the total number of practicing to the number of beneficiaries. And geo access evaluation is growing in frequency in its use. We found 13 states are mapping the enrolled physicians to look at geographic access. Just eight states rely on the HRSA shortage area definition as their main designation of access concerns.

Three states are doing physician workforce surveys, and two states are looking at the percent of a provider's panel who was Medicaid patients.

The last set of questions that we asked about where: What would you do if you discovered a problem with access in your state? The majority of states have a very prompt, personalized response to an access problem. They call a doctor, they call the medical association, they call the health plan, and they say here is the patient, here is the need, fix it. And they feel satisfied that when they do that it happens.

There is also a second step that goes on there where the Medicaid director described looking at: Is there a pattern here? Have we heard this numerous times from a number of people? Do we need to get to an underlying problem? So directors do review data to investigate whether identified problems are widespread. We heard that in 19 managed care states -- high managed care, and 10 low managed care states.

We also heard about solutions that were directed at the associations, so doing that work and outreach work with professional associations to encourage new provider participation where there has been a shortage.

And, finally, in high managed care states, the Medicaid directors did report that they would expect their health plans to do that recruiting and expand the network into shortage areas.

MS. HERMAN: And I will conclude this presentation with some next steps and issues for your discussion.

As I stated in the beginning of the presentation, the survey is the Commission's first effort to collect information to develop an analytic agenda for examining access to care in Medicaid and CHIP. Ideally, the survey will help the Commission to leverage information about existing monitoring activities and current data colleague methods for Medicaid and CHIP enrollees, and we hope that the survey will assist in helping you to avoid reinventing the wheel on your work on access as you can hopefully build future work on existing state policies and efforts.

We propose several next steps for your consideration to build upon these initial survey findings to look at this issue in greater depth. And the following suggestions would allow you to both drill deeper into how specific states examine and resolve access issues and collect data on these efforts, as well as to continue to amass information about state variation in policies and practices for monitoring access.

First, we propose that the Commission could conduct in-depth interviews with a subset of states with different characteristics, such as states that are geographically diverse, that have different service delivery models, different combinations of risk-based managed care, fee-for-service, primary care case management; states that have different data collecting and reporting capabilities; and also states that have a mix of formal and informal systems for monitoring access issues.

Also, a few states in this survey who have predominantly fee-for-service programs responded that they do use some access measures in their attempts to monitor access. The Commission could look more closely at these practices to consider whether fee-for-service programs could develop a more formal monitoring system to look at access issues.

Also, the Commission could consider whether findings regarding risk-based managed care might warrant a more in-depth review of Medicaid managed care contracts to look at different access standards across states that work with these plans to deliver care.

And then, lastly, there may be other activities, analytic activities for the Commission's

discussion that could build upon the information collected in the survey.

Thank you.

COMMISSIONER HENNING: I am just noticing when you -- you're kind of using provider and physician interchangeably, and in Burt's honor, and also from my perspective as a nurse practitioner and a certified nurse midwife, I was just curious if, when you talked about provider access, if you were also considering nurse practitioners, nurse midwives, physician assistants, and other providers of care that may not be physicians.

MS. EDWARDS: I think that the way that we worded it in the survey would have led the states to respond for all providers generally speaking. We didn't word it in a way that steered them towards one type of provider, but we didn't ask specifically about each type.

COMMISSIONER HENNING: Okay. Thank you.

CHAIR ROWLAND: You did ask specifically about in their fee-for-service program, right?

MS. EDWARDS: We asked specifically for them to comment on specialty access and dental access, and they largely overlooked those instructions. They gave the big-picture answer without a lot of specificity.

COMMISSIONER COHEN: I'm just curious to get a little bit more in-depth on this distinction between the high managed care penetration states and lower managed care penetration states. First of all, just some insights from you, generally what kinds of differences you saw and what you attribute them to. In other words, do you think that the penetration is a proxy for something else, like more urban or more dense populations? Or is it something else? In other words, I guess do you think the differences are a cause or effect of the high managed care penetration?

MS. EDWARDS: Well, it's clearly administrative --

COMMISSIONER GABOW: I wanted to add something to her question before you answer that. Was that a clear break at 30 percent? Or when you graph out a distribution, you know, you had a lot of 28, 29, 31, 32, and you arbitrarily picked 30? Because that would make a big difference in the answer to your question.

MS. EDWARDS: Yes, I remember there being a big drop. We did look specifically to see was there a logical point, because I was actually surprised it was as low as 30 before you actually got a big enough drop-off after that. I want to say it was about a 10-point drop after that, but I can check afterwards and just check.

But I think that the issue is that largely this is an administrative strategy that states take on, right? So if you have enough density and you can get managed care plans to come into your states and provide services, then it's a business strategy to give them all that responsibility for creating networks and monitoring them and reporting back to you. And if you don't have enough managed care or you've got an environment where they're discouraging managed care, then that responsibility has to lie with the state to do all that work. And so I think that the state's capacity to do that work then has to be supported by their information systems and having a staff who can make provider networks.

So I think that there's -- I know that there are states that have both, but when I think about the states that I've worked in, I think of them as being largely a managed care state or largely a fee-for-service state, or even with a big PCCM program, but that the staff are responsible internally versus contracting that out.

COMMISSIONER COHEN: Was that sort of a hypothesis when you started that there would be differences?

MS. EDWARDS: No. That was one of the things that the staff looked at the data with us and they said, you know, we really need to just split this because there's obviously a story going

on here. No, we didn't go in -- I think had we gone into it with that hypothesis that there would be such different strategies, we might have asked the questions more structured, each one say, okay, for fee-for-service what do you do, for managed care -- because many states do have both. But instead we got the number one answer that they thought of, and then we had to step back and say, okay, which are you, a managed care state or a fee-for-service state.

MS. HERMAN: Also, I wanted to point out to you that a lot of these findings, breaking it between high managed care states and low managed care states was a reasonable way to distinguish between the different types of activities because there were differences. But you could also -- we also looked at this in terms of risk-based managed care programs in states, whether or not they met the 30-percent threshold or not. So there were states that were low managed care states but do have a risk-based program that did give some answers about what they do in their risk-based managed care program.

So, for example, one question asked about whether or not they used contract requirements to monitor access. All of the high-risk states did, but then also some states that we deemed low managed care states did as well. It's just that their predominant system was not managed care.

COMMISSIONER RILEY: I'm always struck with what blunt instruments we measure access because for me the important thing is access to what and how appropriate is the service. And as we well know, more is not better. And the number one monitoring strategy is complaints and grievances.

Have any states done anything to measure what the appropriateness of -- my perceived lack of access against appropriate access? Question one.

Question two: Has anybody ever tried to connect with -- insurance departments do have regulations on health plans about network adequacy. Has there ever been any kind of a crosswalk to look at what they do and what we do?

MS. EDWARDS: Yes, I think that's a kind of question we would need to probably follow up and ask them in that phone call. We didn't try to get at did you -- so the question is did you agree when someone said that they had an access problem.

MS. EDWARDS: So was it appropriate -- was it excessive asking? Yeah, I don't have any data on that.

EXECUTIVE DIRECTOR ZAWISTOWICH: Trish, just two points regarding the question about appropriateness. Really we just wanted to get a sense of what states were doing, and we'll dig deeper into those issues. And then the notion of looking at what NAIC is doing, I think that's really important and will be part of our next efforts on this.

COMMISSIONER MOORE: I'd like to get your sense -- and, again, this may be something for next steps -- of the consistency that you saw across states. Obviously, if they're using CAHPS and HEDIS, that's consistent. But a lot of the other things you described seemed to me to be probably homegrown and invented at, you know, X agency in Y state.

And that then leads me to another question, which is: Is there a source for ideas for states about how to do this? Is there a best practice? Is there technical assistance provided by CMS? Is there regulatory or manual or other kinds of guidance around this? Or do states just invent it all on their own?

MS. EDWARDS: My sense is that the states are inventing it. In fact, one or two states wrote back to us and said, "If we only knew how to measure access, if the feds would only set a standard for us, we would certainly follow it. But in the absence of that, we wait for complaints to come in." So that was one or two states.

And then there are states who are really quite inventive. They've set their whole analytic capacity to work on this problem, and they described some really wonderful reports.

So I suspect that somewhere in these reports are some nice national -- potential future

national standards and best practices, and we'll try to bring those out in the report that we submit in May profiling the couple of states who are really quite advanced in doing this, and maybe they've partnered with an academic group or maybe they've got in-house capacity and great data.

COMMISSIONER MOORE: You didn't see any particular consistency across a large number of states?

MS. EDWARDS: No, surprisingly not consistency, but people -- we also didn't ask them to specify their measures. You know, if we were to go back and do it again -- you know, some of them volunteered, "We're looking at preventable hospitalizations, ambulatory care-sensitive events, emergency room spikes." And one or two of them said they have a dashboard, which, you know, had we gotten that one by phone, we would have said, "Please send us your dashboard." But we need to go back and ask more about what they actually measure.

COMMISSIONER GABOW: I think for our managed care report, what we heard from the panel and what we're hearing somewhat from you is that the managed care plans actually provide a structural basis for doing a lot of things which you would like to have done in an insurance plan, which I guess we could say loosely Medicaid is. So I think we didn't talk at all about that benefit of managed care, but dissecting that out a little bit more might be quite useful for the previous report, I think.

CHAIR ROWLAND: Other questions or comments?

COMMISSIONER HOYT: Maybe just a short one on provider shortages. It could be related to geo access or any of those issues. When you're looking for physicians who are enrolled in the program or who agree to see Medicaid, is there any way to probe that further and see if they see at least a hundred different patients, a certain number, or just, "I see eight Medicaid patients"?

MS. EDWARDS: So we didn't ask them exactly what their measure was. We asked them if they -- how they would know if they had a physician shortage, a provider shortage. So, again,

they didn't specify what the measure was that they're using. They would tell us that they had some standards.

COMMISSIONER HOYT: I'm kind of out of date on this. The geo access software, has it been improved so that it maps to where the provider really is or to the billing address? Do you know what I'm talking about?

MS. EDWARDS: I do.

COMMISSIONER HOYT: Because I used to --

MS. EDWARDS: I know exactly what you mean, yeah.

COMMISSIONER HOYT: Because it used to give you like a false read before because it was mapping to some billing address, and that's not where the clinicians were.

MS. EDWARDS: Right. So it depends on the sophistication of the registry, the provider file that the states keep. And so some states keep a provider file with multiple addresses for a doctor, and maybe best hope is that you've got the practice location as well as the doctor's ID.

I can tell you that I can name at least one or two states that were really good at this. I don't know if that's the method that everyone uses because not everyone shared the details with us.

COMMISSIONER CHECKETT: I was curious. Did you receive any or ask or perhaps we should think about -- but it's great to ask, all right, you know, how are you monitoring access problems. But did you get any feedback or ideas on what you do, what the states are doing when they identify it?

MS. EDWARDS: Yes. So that was interesting to me how often it was that people said, "We just fix that problem. We just jump right in and make that person's problem go away for them, while we also look at our data to see if it's a pervasive problem or if that was a rare event."

So we got the impression that the phone is still a mighty tool in improving access, and then they go back and they look at -- they either ask the health plans to do this for them, or they do it

with their own data to see, you know, is this a real shortage problem.

CHAIR ROWLAND: If that's an individual solution, did you find any difference between states with large Medicaid populations and those with relatively smaller populations? Is that harder to do, a one-to-one solution, when you've got 2.2 million instead of 225,000 enrollees?

MS. EDWARDS: You would certainly think so, right? I guess what I found, though, was that it was so commonly said that -- I mean, I can go back and check the actual number, but it was so commonly said that you got the impression --

CHAIR ROWLAND: That every state did it.

MS. EDWARDS: That every state did it, yeah.

COMMISSIONER COHEN: I saw that there was --

CHAIR ROWLAND: Didn't they do it one by one in New York City?

[Laughter.]

COMMISSIONER COHEN: I think they tell the plans to do it.

I saw that there were a number of the things that states looked at focused a lot on primary care access, but what we keep hearing is that in many places, at least, the much harder nut to crack for Medicaid beneficiaries is specialty access. So I'm just curious. Again, some observations on that. When states are looking at access issues, are they looking comprehensively? Or are they really just looking at primary care?

MS. EDWARDS: Yeah, I wish I could say a little bit more about that. The problem with these open-ended questions is that they told us what they wanted to tell us, and so we didn't have a way of probing on that issue: "When you said that, did you mean that for all providers or just for primary care providers?"

What I can try to do, though, in the next write-up is to pull out any place where there were comments on specialty care, I can make sure to pull those forward so that we can see if there is a

story there.

COMMISSIONER HENNING: And sometimes I wonder if the state Medicaid director would really know if there are certain problems. In particular, I'm just thinking of my own example where we had a problem for a while where the doctors that do our deliveries were willing to take the Medicaid payment for the C-section but not willing to take the $50 extra to do the tubal that takes them two minutes until the health plan stepped in and basically intervened for the patients. But because Florida -- and, apparently, I guess this is across the country. Because birth is considered an emergency payment for people that don't have insurance, the undocumented workers in particular, they will pay for the C-section for someone that needs it, but they will not pay for the tubal, and our doctors that do the C-section make them pay an extra $240 for that two-minute procedure. And these are people that don't have any money, so they don't usually get the tubal. So we get another pregnancy down the road, and, you know, we pay for that, too.

So I think sometimes we are penny wise and pound foolish when it comes to some of these things. But, you know, this is just -- this is one of the many access problems that I run into. But, you know, just like cardiology consults, I cannot get a breast reduction for a woman that clearly needs it. If she has a gall bladder that needs to come out, she has to go to the ER, and maybe she'll get it done and maybe she won't, and she'll probably have, you know, four or five visits at the ER, at least, before somebody will take it out for her. And it just seems to me a really bad way to provide care.

MS. EDWARDS: So what you're suggesting is that it's possible for a provider to come up with a list of things that you might actually actively look for evidence that they're being delivered or not being delivered.

COMMISSIONER HENNING: Right.

MS. EDWARDS: Rather than waiting someone to raise a red flag that is not being done.

COMMISSIONER HENNING: Or maybe it's my responsibility. Maybe I should be calling the state Medicaid office and saying, "Hey, you know, I can't get a hysterectomy for somebody who's got fibroids and an 8.4 hemoglobin because she's got Medicaid and nobody's willing to do it at Medicaid rates."

CHAIR ROWLAND: And I think we're hearing that if you call, that one person might get --

[Laughter.]

MS. EDWARDS: -- systematic solution, right.

CHAIR ROWLAND: But what we're trying to look at is broader than case-by-case solutions to these issues.

COMMISSIONER WALDREN: I was thinking about that, the case by case, and yet my first blush thinks, oh, that's great, they really care and are really trying to help individuals that say they have a problem. But then I think, well, maybe we should do a little more follow-up, and maybe that's just a default, because if somebody calls and, you know, the squeaky wheel gets the grease, but do they really do that? Was there any data -- probably not any data because it was open ended -- about, well, how many did they get and when was the resolution and how was the resolution tracked? You know, so a little bit more data than when they call we help them out, but what actually happens to say how much does that happen. And going back to my experience as a physician and as a provider, do you deliver good quality care? Of course I do. I wouldn't do anything else. So it makes me a little bit nervous now that I think about it a little bit more.

MS. EDWARDS: It seems as if having a standard would make it easier to know whether you were satisfied with the answer or not. But there's not really a clear standard yet.

CHAIR ROWLAND: Okay. Well, we will look forward to reading the full report, and thank you for updating us. And, obviously, this is just the tip of the iceberg in terms of what we're

going to have to look at in terms of how access is monitored and measured or not monitored and measured, as the case may be. But thank you, Jennifer and Michelle.

And now this is the portion of our meeting where if anyone from our public has a comment, please stand and state your name and your affiliation, and we would be pleased to hear any comments you might have for the current topic or other topics that MACPAC should be addressing.

#### **PUBLIC COMMENT**

* DR. McMENAMIN: Hello. I'm Dr. Peter McMenamin, senior policy fellow with the American Nurses Association and health economist for the association. Some of the Commissioners knew me when I was chief of physician reimbursement research for Medicare and Medicaid and directed the Grant Review Panel for ambulatory care research at HCFA, and some others on the staff knew me when I was director of health care financing policy at the American Medical Association. So I've had a long history in provider participation in Medicare and Medicaid and other insurance programs.

Since I'm working now with the American Nurses Association, I hope I can help and I hope you can help me in terms of getting more data on the participation of advanced practice nurses in Medicaid and Medicare.

When I was back at HCFA, it was very clear that Medicare data was better than Medicaid data. That situation is changing, but unfortunately it's because Medicare data is getting worse.

[Laughter.]

DR. McMENAMIN: I can tell you that I have looked at the file of national provider identifiers that CMS maintains. There are 152,000 individual APRNs who are in the file in every state, for all four of the APRN rolls. Unfortunately, CMS either refuses or can't find the numbers on how many are participating in Medicare only, how many are participating in Medicaid. I can tell

you based on the volume of services provided by nurse midwives that if all of the nurse midwives with the national provider identifier were in the Medicare program, they'd be averaging $25 per year. So, obviously, there are a lot of them who are more in Medicaid.

I have had no success at all getting the Medicaid numbers in terms of practitioners who are involved in the program, signed up, eligible, on the rolls. But according to HRSA, in 2008 there were 250,000 advanced practice registered nurses in the United States, and they represent a potential contribution to alleviating the access problem for the uninsured and for Medicaid if only they were allowed.

You do know from the recent Institute of Medicine report that there are state restrictions on scope of practice that, if relaxed, would allow more advanced practice nurses to participate.

We have heard anecdotes -- don't have any data -- that advanced practice registered nurses have difficulties getting onto the rolls of networks of managed care plans. I assume that is true for some Medicaid managed care plans, but it is an important issue, and if we can better document what the impediments are, I think there are ways, without waiting for graduating more physicians -- not that that's unimportant, but there are ways to provide better access to primary care, and we have them at hand if only we could release them.

At any rate, just a comment.

CHAIR ROWLAND: Thank you for your comment. I think you can tell from some of our discussions that the role of advanced practice nurses is one that this Commission is going to take a hard look at and is part of what we are going to have to address with regard to access to care.

We had hoped to also have a companion commission on the workforce that would be looking at some of these issues. That has not yet been able to be put together with funding, so we're going to have to go it alone. But we welcome your comments. Data is obviously one of our challenges as well, but we will try to fill in the gaps wherever possible and to maybe prompt

others to collect better data. So hopefully the Medicaid data and Medicare data will both get better over time instead of going in the opposite direction.

Any other comments?

[No response.]

CHAIR ROWLAND: If not, then we will adjourn this session, and we thank you for your participation and look forward to having you back for our next meetings. Thank you.

[Whereupon, at 3:24 p.m., the meeting was adjourned.]