MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

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1:42 p.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
RICHARD CHAMBERS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
PATRICIA GABOW, MD
HERMAN GRAY, MD, MBA
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH
STEVEN WALDREN, MD, MS

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P R O C E E D I N G S [1:42 p.m.]

CHAIR ROWLAND: If the Commission could please reconvene.

[Pause.]

CHAIR ROWLAND: If we could please reconvene and welcome the participants to this portion of the Medicaid and CHIP Payment and Access Commission meeting.

We have been meeting since last September. As most of you know, we released our first report to the Congress in March, and we are now heavy into the process of preparing a second report to Congress to be issued on June 15th, which will take on the topic of Medicaid and CHIP and managed care, and we will try to provide the same context and overview for that role within the program as we provided for the overall program statistics and issues in the initial report in March. And this one is in the frame of the Congress asking us to look at how Medicaid and CHIP fit within trends within the overall U.S. health care system, so this report will provide some context on the evolution of managed care in the Medicaid program, how it's handled in the CHIP program, and where we'll be moving forward.

So we wanted to start our meeting today with a panel that will review on the part of our staff person, Lois Simon, some of the work that we engaged in thus far in managed care, and then really turn to Mike Fogarty from Oklahoma and Jason Helgerson, now from New York, previously with us from Wisconsin, to give us some additional state perspective on how these issues have been evolving at their state programs.

We will also be, for the record, commenting on the access rule that came out from CMS recently and are going to have to start working on putting together the Commission's comments on that rule and on the overall issue of where we go forward on our own agenda with access to care and payment policy issues.

But for today, I would like to turn first to Lois and begin our deliberation of the managed care

report that we will be putting forth to the Congress and to hear from our state guests, and I welcome them both, and to you, Lois, thank you.

REVIEW OF MACPAC DELIBERATIONS AND WORK TO DATE ON MEDICAID MANAGED CARE

* MS. SIMON: I have a new technology here. So given the dominance of managed care in Medicaid today, managed care has been one of the Commission's top priorities from the start. To learn what there is to know, we have undertaken a number of activities on Medicaid managed care and have devoted a number of presentations at public meetings on the topic. And with recent state trends towards managed care expansions and the potential of even greater increases in 2014, as Diane said, the Commission has decided to focus its June 2011 report to the Congress on Medicaid managed care.

And much of what has been learned from the activities undertaken by the Commission since last fall is being incorporated into the draft managed care chapter, which I will present later on this afternoon. But right now I will briefly summarize the Commission's efforts to date on Medicaid managed care.

At the October meeting, staff provided a general overview of Medicaid and CHIP managed care, highlighting why states pursue managed care for their Medicaid and CHIP populations, and trends in the most common models being used by states. The December meeting included presentations on what is known about access and payment.

A literature review on Medicaid and CHIP managed care synthesized what is known about how states implement and monitor their programs and managed care's influence on enrollees, access, outcomes, and program costs. And a key finding was that there is a big gap in information and on data on characteristics and program performance and that studies that have been done show really mixed results and

varying methodologies making comparisons difficult.

And findings from an expert roundtable discussion on Medicaid managed care that was convened by MACPAC in mid-October were also shared. Sixteen experts with a range of relevant operational and research experiences shared their perspectives on the current and likely future role of Medicaid managed care, and CHIP, too.

In December, staff presented a proposed work plan for MACPAC's future analytic work in the area, and the work plan was designed to gain a better understanding of the key characteristics of state programs, make comparisons across states, and track trends over time.

From the beginning the Commission has voiced an interest in learning from a range of stakeholders on issues relevant to the Commission. Gaining insight from states on how they implement, manage, and monitor their managed care programs is important in our review of Medicaid managed care. At both the September and October meetings, Medicaid directors shared extremely valuable and unique on-the-ground perspectives.

At the April public meeting, four representatives from managed care plans discussed their concerns in Medicaid managed care today and what they see as the key opportunities and challenges for the future.

STATE EXPERIENCES WITH MEDICAID MANAGED CARE

MS. SIMON: Today the Commission will gain new knowledge on state strategies on Medicaid managed care. We will be hearing from Medicaid directors from two states, as Diane pointed out, and these states have very different histories and experiences with managed care, and they also rely on different types of managed care models for their Medicaid populations.

Jason and Michael will discuss their experiences with managed care and their states' rationales for

pursuing this delivery model as well as current initiatives that are going on in their state with regard to managed care. We also hope to hear from them about what they see as the challenges and opportunities in the future.

I will turn it over to you.

* MR. FOGARTY: Thank you very much. Diane, thank you for the opportunity. I'm Mike Fogarty, the director of the Oklahoma Health Care Authority. We are the designated agency for Medicaid and SCHIP in Oklahoma. You don't need to worry about looking at a screen. I don't have PowerPoints today. I just want to visit.

It will come as no surprise to any of you that when you look at a Medicaid program, you really are looking at a unique situation. It's hard to find common ground, although I think at the core there's a lot of common ground.

I want to put, first of all, the evolution of the use of managed care in Oklahoma in a bit of a historical context because I think it's only through that that we can really understand how we got there and decision points along the way.

I would suggest that it would literally not have been possible to go from where we were in a 100-percent fee-for-service program to the model we now find ourselves operating without having gone through that evolutionary process.

So we joined a majority of the states in the mid-1990s, reacting, as most were, to budget difficulties then. All words that are familiar: unsustainable increases in Oklahoma of increased costs in Medicaid more than doubling the general budget of the state. I think four years, from '88 to '92, an increase of some 81 percent compared to 30 percent in the general Oklahoma economy.

The answer at the time, it was decided, was managed care. Managed care, as you know, in those days meant almost, if not literally exclusively a fully capitated HMO or MCO delivery system. So we started with legislation in 1993 authorizing, actually mandating that we convert Oklahoma's Medicaid system into a fully capitated managed care program to the extent possible statewide.

That early design included contracting with fully capitated HMOs for approximately one-half of the Medicaid population in those urban areas -- you didn't know we had urban areas; we do -- where there was actually currently commercial markets for fully capitated HMOs.

The unique thing and what brought us to today was the fact that we also in those areas in rural Oklahoma attempted to create a unique, really, at the time, model, a primary care case management model that was also capitated in the balance of the state. Both of these programs were mandatory for enrollees, starting with all the categorical relationships, the TANF Medicaid enrollees, and later also mandatory for ABD population.

That experience went rather well, implementation of the fully capitated program in 1995, summer of 1995, followed a year later by the implementation of the PCCM program. By the way, those were both -- they had labels: SoonerCare Plus implying, as was the case, that the benefits were much richer, did not have the traditional limitations of the fee-for-service program in our fully capitated program, and SoonerCare Choice, which was intended to reflect the choice of primary care practitioners available to those who would be enrolled in the PCCM program.

That PCCM program depended almost exclusively on the PCCMs for all care management. We didn't have a back-up system to bring care management to that population. So I point that out because it becomes an area of a lot of effort later.

Our early experience was that we had great success financially. There was, as we say, a lot of low-hanging fruit that the capitated system squeezed out of the program. Whether that was inappropriate utilization or just utilization is probably not totally clear. But the fact is there was a lot of money to be saved. It is pretty easy to do, as you know, in a fully capitated system because you just set the rates at a number lower than your current experience in fee-for-service. PCCM was not quite that simple.

The challenges of the fully capitated program fairly early on was a bit of a surprise, and that was the turnover. Companies were hungry for that business. They weren't bashful about low-balling in the competitive bidding process. And so in the early years, there was substantial turnover in our fully capitated program.

The challenge of the PCCM program at the time was capacity. Oklahoma remains, I believe, the state with the lowest ratio of primary care practitioners per capita of the many states, so we never enjoyed the luxury of having a large supply of providers that drove at least a segment of them toward the Medicaid program. We were in a marketplace competing with a fairly tight supply.

In response to that, we established our capitation rates early on in a financially attractive way. We made assumptions that, because of the savings on the utilization side and, frankly, on the longer-term effectiveness side, we could make up the difference of about a 16-percent overpay on the capitated benefit side.

Now, the PCCM program, as I said, was a partially capitated program. That program, the cap was about 10 percent of the total benefit. It involved office-delivered services by primary care, including some office-based lab, x-ray and that sort of thing. It did not include any external. All specialty and external services were still fee-for-service but were managed by referral by the PCCM.

We also extended those contracts to advanced practice nurses and physician assistants, and just a footnote, those primary care practitioners were paid the same rate as a physician practitioner, and we may want to talk about that a bit more.

In '99, as I said, the statute required -- actually by the initial statute required the ABD population to also be rolled into that managed care model. We delayed that for 2 years just to try to get a bit more comfort level that both systems could handle that population. We did fully implement that in '99.

Another thing that was a by-product of the fact that the system responded so well early on financially was that we were able to expand the program by increasing financial criteria for both children and pregnant women as early as 1997, and then just a few years later we also were able to increase the adult population. The children and pregnant women went to 185 percent of federal poverty. The adult went to 100 percent of federal poverty. So the numbers grew fairly rapidly after that.

Well, I mentioned that in those early years we squeezed on the budget side a lot of the more easily found savings that I referred to as low-hanging fruit.

Very early on, about the time we started dealing with the tail end of the good news on the budget, by 2002, 2003, that was starting to turn around. We were seeing very large increases particularly in the fully capitated side, driven by the enrollment of the adult population, obviously, as well as the fact that they really had accomplished about all they could, and so now we were back in an inflating cost.

But what became apparent by that time was that we were getting very good results on the PCCM side. We had started formally publishing what we called "Minding our P's and Q's," which were annual reports of both CAHPS and HEDIS, and we had comparable data between the fully capitated plans and the PCCM that produced some very encouraging results on the PCCM side.

About 2003, as we approached the contract year, 2004, we were down -- I mentioned plan turnover. We were down to three plans. They all bid separately on the three areas that I mentioned, those urban areas in Oklahoma. We were down to three plans, and we had only two in each of the three areas. So obviously we were at the minimum. There is some thought that that put the plans in a position of having a great deal of leverage. Obviously, we couldn't operate with fewer than two plans under the federal rules at the time.

So in 2003, approaching '04, the plans -- the actuarially certified rate parameter was a range. They demanded the very top of that range at 18 percent. We offered something much lower in the range at about 13.6 percent. A couple of the plans were ready, I think, to do that, but the bottom line, we were in a position where we were not going to be able to buy and meet the federal rules with anything less than an 18-percent increase.

So that was our opportunity. As I like to say, we thanked the plans for their participation and looked to the PCCM program to come behind those plans statewide. So we did that effective the 1st of January of 2004, and we've been in a statewide PCCM program since that time.

It was at that time that a couple of things happened that benefitted us greatly. First of all, we had audited financials that gave us a good number, a credible number on how much we were spending in the capitated premium on administrative overhead, including care management. And we knew from our own analysis that we could offer that in our delivery system at a fraction of that cost.

We also were in a unique position to demonstrate to our policymakers that those three plans had about 400 employees providing those functions, and we were confident we could do that with as few as 100 employees. It's not every day that a director of a Medicaid agency can walk into the state capital and leave

there with the authority to hire 100 new employees. They would not give us 100. They gave us 99.

[Laughter.]

MR. FOGARTY: One hundred was just going to push it. So we did get 99 to support the statewide delivery system on the PCCM side, which meant we could hire some 30 to 40 RN nurses as care managers, also social workers as system navigators. We also extended the reach for the first time of that care management function to what had been the PCCM program. We were no longer dependent on just the primary care providers themselves to do that case management.

The result was that by 2006 the legislature -- of course, now you are talking 10 years later, so it was time to reform Medicaid again. And so in the 2005 session they established a commission to reform Medicaid in Oklahoma. That produced even more support for our establishment of what really became a publicly operated statewide MCO. And, in fact, that is what is being operated in Oklahoma today. They actually mandated that we procure the services of more nurses for a major push in health management, not just care management but health management.

We also then on that foundation moved toward a more fully developed medical home model. This model was the beginning of the next evolutionary development on the payment side. We went from a partially capitated delivery system -- and I'll tell you, there -- we like Will Rogers in Oklahoma. He had great ways of putting things in very few words, and we could all understand them. We developed a couple of filters in Oklahoma that have continued to guide us. The policy filter in Oklahoma to this day -- and for now about 15 years -- has been it's health care, not welfare. And you have seen that and heard it. And some are offended by it, and I apologize to those who are. But the fact is every policy decision in these past 15 years has had to pass muster under that filter. If it moved us towards something that looked more

like health insurance, health coverage, then it passed the test. If it moved us toward something that looked more like the welfare system -- and I can talk about some specific examples.

The other filter on the payment side was similar, kind of cute. It is the best way to get -- I think I can remember it. The best way to get what you pay for is to pay for what you get. If you want physicians to be excited about creating large panels of covered lives, pay a capitated rate, and you will have physicians that figure out very quickly that that's a lucrative system to establish those large panels. If you want patients to be served in those offices, you might look to paying for the services that get rendered in those offices.

If you want the provider to engage in care management, pay for care management. If you want the provider to deliver certain kinds of services and produce certain results, pay for those results. If you want providers to compete on the basis of performance, measured by any way you want to measure it, pay for their achievements on those performance measures.

And in our medical home evolutionary system, we went to a system that, in fact, now pays -- there's no longer capitated services. They are direct services paid for fee-for-service. The case management function comes in three forms and three tiers. Depending on what level of commitment that practitioner is willing to make in terms of the functions of the medical home, they will get paid a different rate; the more they commit to, the higher the rate. They also then in addition get paid performance amounts based specifically on the classic EPSDT screens, now expanded also to breast and cervical cancer screens and other early interventions. We also pay them bonuses if they have relationships that involve attending to their patients when they're hospitalized.

Now, we snuck one in, and that is, we also pay a bonus to those who prescribe generic medication.

That's obviously got some budget ramifications. And there are several others on that front.

The medical home has now been fully evaluated. You have seen, I think, some of those documents on our website, and perhaps some of them were produced for this meeting. I'm happy to go into that, and I note the author of some of those evaluations is with us today as well, Mr. James Verdier.

The care management and coordination function is one that I say I think there was a unique opportunity for us. We were able to take advantage of that, and it has produced results. We went from a system -- the only state-operated care management supplementation that we did in the initial program was a 24/7 phone line for enrollees who were seeking some help with the system and a 24/7 phone line for practitioners who were needing help with the system, including perhaps finding a referral source. So it wasn't absent any of that, but that really was it. That has now grown, as I've already described. I won't go through that again.

The evolution of the care management program also now focuses on a number of conditions, including high-risk OB, transplant, catastrophic illness or injury, all women who are enrolled in our product we call Oklahoma Cares, which is the coverage for breast and cervical cancer, and all children receiving in-home private duty nursing.

We've also developed and pay performance bonuses for low ER utilization. If anybody has found the magic bullet for reducing inappropriate ER utilization, we'd love to learn from that. I will tell you that we started that effort through care management and transferred it to member education because we discovered early on it was in virtually every instance not so much an issue of managing the care as it was educating the enrollee on why it was better and why they had the option of going to see their primary care physician.

I've already mentioned the health management program that continues to develop. We're now seeing about 5,000 of our highest cost and highest utilization members through an additional 32 to 35 nurses. Those, however, were -- they're online through contract, through an organization. We didn't hire those directly. There's a limit to what even the Oklahoma Legislature will authorize me to hire.

But those have focused on those beneficiaries, and it uses predictive modeling based on claims payments so that they're not reacting to things that already exist every time. They are often proactive in a case where we look at the history and we can predict where that's going. And so they intervene at that.

Physician reimbursement changes I think have probably contributed one of the most significant factors in a state that has a challenge of accessibility. It's not only paying more for the service, and we raised our rates to 100 percent of Medicare across the board in our fee-for-service program. Sadly, a year and a half ago, as a result of revenue failure, we had to reduce that by 3.75 percent, so we are still 3.75 percent under Medicare, but even at that are, I think, among some of the highest.

There was a day early on, even 15 years ago, when our participation in that marketplace really accommodated us buying those services on what I view as the margin so we could go to providers who could sell us a marginal part of their practice and could afford to do that at very, very low rates.

We now have 20 percent of the state's population enrolled this month in SoonerCare. Obviously, the percentages are much higher for children. Something over 50 percent of children are enrolled. Well over 50 percent of the pregnant women in Oklahoma are enrolled in SoonerCare. So that's not the margin. We now have to be in that marketplace as a legitimate, major, the largest purchaser of health care in the state.

So I think those things have come together well for us, and they have worked. There clearly are

still challenges, particularly in today's budget squeeze, but I am anxious to respond to any questions you might have. I think you may want Jason to go ahead and make his presentation first.

CHAIR ROWLAND: Yes, thank you, Mike.

Jason, why don't you give us your perspective from New York? And if you want to throw in any Wisconsin observations, you're welcome to as well.

[Laughter.]

* MR. HELGERSON: All right. Well, good afternoon. It's good to be here again, although in a different capacity this time than when I was here with you, I believe, in October of last year. I'm Jason Helgerson, Medicaid director for the state of New York. I'm happy to be in Washington. This is my first time here since accepting the job. I've been very busy in New York, as Andy Cohen well knows, trying to find significant savings and really try to make some major steps towards reforming the Medicaid program in New York, which today is the largest Medicaid program in terms of total spending in the country. And so I am happy to be here to talk particularly about Medicaid managed care because not only does New York have a long history in this area, it is also something where as part of our redesign efforts that were approved in the state budget back on April 1st makes a major policy shift, which I think is an interesting difference in approach. It shows you how different states are when you hear Mike's presentation about the history in Oklahoma and now what you will hear about what we're pursuing in New York, two different strategies for two different states.

First off, just in terms of the history, Medicaid managed care began on a voluntary basis in New York back in 1984, and since then we've been on a trajectory of expansion, moving different parts of the state and different populations from voluntary into mandatory. Currently there are 3.4 million New

Yorkers who are enrolled in some form of managed care. There are over 20 different managed care organizations currently contracted with the state Medicaid program.

I guess as someone coming from the outside, I'd say that our system of managed care in New York is fairly complex in the sense of the number of programs and acronyms and such that exist, but to say the least, New York has had a long history, and I think as a result the history might be helpful to this group, both the strengths and the weaknesses, the challenges that are associated with Medicaid managed care.

So, that said, as Governor Cuomo coming into office identified the ever-growing Medicaid program in the state as one of the biggest budgetary challenges facing New Yorkers, I think when we looked at the budget situation in the beginning of the year, decided -- or determined that if we did nothing, the Medicaid expenditure in New York, even with relatively flat enrollment, was going to grow by over 13 percent.

As I said, we have the largest overall spend at $52 billion a year. In addition to that, if you look at it on a per recipient basis, we spend roughly twice the national average in Medicaid expenditure. And as part of the redesign team efforts, we looked very hard and sliced and diced the data to try to understand why those costs were growing at such a rapid rate. And what we found was that while most of -- the vast majority, you know, as I said, 3.4 million of the 4.7 million New Yorkers are already enrolled in managed care, there remains a very high cost population that remains, in essence, in your classic fee-for-service Medicaid system. Some of those people have access to some level of care management services, but it tends not to be fairly well coordinated; and that if you look at those individuals, you see that their costs are growing, and quite quickly, and I'll show you a slide a little bit later on.

As a result of that and the efforts of the team, what we have proposed and now is actually law in the state of New York is basically a three-year trajectory in which at the end of those three years we actually

hope to get the state of New York out of the direct claim-paying business, to end the fee-for-service Medicaid program, and, in essence, enrolling all of the Medicaid members in New York into some form of care management. And I use the words "care management" very explicitly in the sense that -- and I think you've seen some proposals out of other states, Florida I think probably the most recent one, and managed care traditionally seen, and particularly seen by some of our advocacy groups as your traditional insurance company model of managed care, and that is not what we envision in the state of New York, particularly for some of our special more complex populations. We can talk a little bit about that as well.

So the big question is: What will care management for all look like in the state of New York? And I think that is the key challenge as we look -- and I'm glad that the proposal is to take, in essence, a three-year phase-in -- is that we really do need to identify new partners. We need new organizations to step forward. We need to identify new pay models. Obviously, full capitation will be part of that, but also potentially partially capitated programs. This is not intended to be an initiative to have the entire population turned over to insurance companies, although the insurance companies do play a key role and will continue to play a key role. But we also see significant provider-based plan options coming to the table. We already have several of them. They're very successful. We hope for some of them to expand, but also we expect new entry into that market as well.

If you had asked me how many entities we think we might contract with, I would not be surprised that by year three it's somewhere in the range of 75, 80 potential different entities that the state contracts with some form of care management. And I think that I -- we see care management for all as a much more diverse final outcome than I think some of the other states who are pursuing this direction.

Another key challenge is that there are a lot of other care management strategies that have already

been launched in New York and around the country and also new ones being planned that we need to make sure are fully integrated, basically woven into a coherent strategy. I'll just mention two of them:

Patient-centered medical homes, a lot of interest in that issue. I think New York probably has more Medicaid members in patient-centered medical homes than virtually anybody in the country, about 600,000 of our members are currently enjoying Level 3 patient-centered medical home services.

And then now the new concept of health homes. States are chasing the 90/10 funding. These are, you know, plans designed to provide integrated services to very complex populations, a lot of whom are really driving the Medicaid expenditures. And we're working on this as well. We need to make sure that those new health homes are integrated into this care management strategy.

All right. So why care management for all? Obviously, I've mentioned cost, but there's three other categories that I think are important to mention in terms of why we think this is a good model for New York.

First off is that we've had experience with this program, as I said, for many years, and we've seen that as a result of people enrolling into managed care, care management strategies, that it actually can increase access to necessary care. Obviously an important subject for this group, and I've got some data I'll be happy to share as well. Also, higher quality, better outcomes.

We had a lot of data, particularly on the mainstream elements, our low-income family portions of the program, for which there's very strong outcome data. We have plans that are performing at basically equivalent levels and HEDIS measures to what you see in the commercial world anywhere in the country. There's still work to be done there. We need better measures for the long-term care piece, which is really where we're going to be expanding into mandatory areas soon, and so there's more work there. But we

definitely think that our past experience bodes well for the future.

And then, finally easier administration, and I emphasize this because I know this group obviously played a big role in the access regulation, stirring up my colleagues all across the country, which obviously applies in fee-for-service. But as a former Medicaid director in another state and a current one today, the amount of time that my staff and I spend on what I would say is a somewhat onerous regulatory environment that's associated with maintaining the fee-for-service program, I see some definite opportunities here by moving everyone into managed care to really streamline and simplify the organization.

CHAIR ROWLAND: Jason, for the record, I think the group would like to note that we developed an access framework for use in our work that the department chose to apply to their access work, which I think is a compliment to the work that we do here. But we were not the collaborators on the access reg itself.

MR. HELGERSON: Understood. Understood.

All right. So just in terms of increased access, you know, one of the challenges, if you look at the numbers in New York, one of the things I think that was certainly striking for me and I think striking for most people is that it's a really sort of distorted spending pattern. We spend a lot, but we tend to spend very little or have spent very little on direct physicians services and a lot on the institutional side, particularly when it comes to ambulatory care, but part of that could be the fact that fee-for-service rates have been quite low. There was a major effort a couple of years ago to rebalance the financing system to shift dollars out of the hospital setting, out of the inpatient into the outpatient setting. It was a hugely debated and discussed issue, but I think it's definitely a positive reform for us, and it's leading to a better balancing moving forward.

Also, in terms of managed care, the state has done a lot to try to -- and we've got colleagues -- Andy Cohen in the city of New York played a key role in this in making sure that managed care organizations maintain sufficient networks. When you move to that environment, the only way you are going to maintain access is you have to watch the organizations you contract with very closely, and that means not just the data but listening and following up on complaints and secret shopping and some of the other things that I think a number of states have done.

This is just some data. Obviously mental health access is a big concern. A lot of people, including advocates in the state of New York, are very concerned that managed care will mean less utilization, less access for people with persistent mental illness. To the extent to which -- and we've had sort of a hybrid approach. For some populations it's in the managed care capitation rates. In other situations it's not. But we think that if you actually look at the data, we've seen actually an increase in utilization, appropriate utilization of mental health services.

CAHPS surveys, it's always interesting to me. I heard a New York City hospital CEO tell me that particularly in New York City it's really hard to get good satisfaction numbers because New Yorkers by their nature are a tough crowd.

[Laughter.]

MR. HELGERSON: So I looked at these numbers, and I was not that impressed, but take that for what it's worth. But I do think that it does show that people are feeling that compared to the fee-for-service world, particularly when you look at the SSI people who are recently moved or newly enrolled out of fee-for-service into managed care, at least we're not seeing large numbers of people saying they're dissatisfied, saying that they are unable to find a physician. I still think there's some work to be

done, and I think these are numbers we'll have to watch very closely to make sure people are satisfied with the programs.

In terms of improved quality, as I mentioned, we have tracked and New York has the second largest percent of capitated rate that's put at risk based on performance. The state of Wisconsin has the highest and I know from past experience decided they were going to go to 3.25 percent because they wanted to exceed the state of New York, so we may have to take a look at that in the future. But we definitely feel that when you put money at risk -- and I know this is my own personal experience in another state -- you will get -- as Mike said, you should pay for what you want to see happen, and I think that's the key thing. How you set capitation rates, how much money you put at risk, and for what outcomes those dollars are at risk is very important.

I'm a firm believer that you don't want to ask plans to do 50 things. You want them to focus on the things that are most important for the populations that they're serving. And that's why as we move forward with mandatory long-term care -- managed care, we need to really think long and hard about what measures we want to set in place so that we make sure that we get the plans working towards the areas that are of greatest importance.

So does managed care really control costs? I think at the end of the day this is the fundamental question. As Mike said, you know, you can generate some short-term savings by doing this. You can just simply take fee-for-service expenditures, add them into a managed care contract at a discount. But the real question is: Over time does it actually control costs? And this is a little bit of a hard one to read, but I think it's one of the more telling charts that I've got.

This looks at the long-term care per recipient spending between 2003 and 2009 broken into a series

of categories. But I will point to really two numbers or three numbers here. The key number -- oh, and I have this working -- is there, 26.2 percent. So per recipient spending on long-term care services grew by 26 percent between the '03 and '09 areas. But when you break it down, you can see very clearly where the costs are growing the fastest and where they aren't growing.

MLTC, managed long-term care program, which actually declined 0.3 percent, that's their managed long-term care program. So as a result, it stayed virtually flat between the '03 and '09 numbers on a per recipient basis.

Now, if you look at the aggregate budget -- I've had this conversation with reporters -- yes, the managed long-term care budget has grown, but it has grown because we've enrolled more people into it. But when you actually take it on a per recipient basis, it has been flat.

On the other hand, look at this number. Home health care, this is the certified home health agencies, and during that same period, grow in these home health costs -- this is a fee-for-service program -- has grown by basically 90 percent. So in the time of this basically five-year period, six-year period, you've seen almost a doubling in the fee-for-service spend, while at the same time the total number of -- we look at it, you know, so the -- I'm sorry. The spending per recipient nearly doubled at the same time that the total number of recipients receiving fee-for-service programs declined. So really the question is: Why is spending growing that fast? And that really, I think, to us was a clear sign that what we needed to do was to really move aggressively to get more people into managed long-term care.

So less admin, I really do think -- and having been a Medicaid director not nearly as long as Mike Fogarty, but for five years -- that the amount of time we spend, the number of staff people dedicated to maintaining all the various rate-setting systems that we do on the fee-for-service side is a huge part of what

we do. In fact, it drains so many resources that I only have four staff people right now responsible for, in essence, holding managed long-term care plans accountable for the contracts they sign. Yet billions of dollars flow through those contracts.

As I see it in my organization, we need to fundamentally shift that as we move out of the fee-for-service business. I'm not, unfortunately, going to be getting a lot of new staff people in this tight budget environment, but we have to find a way to redeploy our staff to things that, frankly, add more value, and I think by moving to managed care will allow us to do that.

Also just to mention, we probably in New York -- I'm very impressed. We probably have the largest, most comprehensive fraud and abuse prevention system with the Office of Medicaid Inspector General in the country, and yet at the same time, everywhere we went with the Medicaid redesign team in hearings you heard over and over stories about fraud and abuse. I think that's a big challenge. It's a longstanding bugaboo for the New York program. There have been many stories in the New York times and elsewhere about our fraud and abuse problems, yet we spend probably more money on fraud and abuse prevention than anybody else. And so I think by getting out of the direct payment business, some of those issues potentially go away for us.

So key steps next. We have a lot of work to do. This is a huge initiative for us. We need new partners. We need new models. We need new payment systems. I'm glad we have three years, but we can't wait. We've got to keep moving on this area.

We also need a new relationship with CMS, and I think this is one where it's key. I've said this before, that in order for state Medicaid programs, particularly in New York with a significant -- I think we've got as many duals or close to as many duals as anyone in the country. We need to find a way to change the

financing relationship for those duals. If Medicaid is going to be sustainable in New York in the long run, we need to find a way that we can share in the savings from better care management for that population, but share particularly where a lot of that savings is going to accrue, which is on the Medicare side of the equation.

I'm excited about the new efforts. We're one of the recipients of the dual grant. We're also on the precipice of getting Medicare data for the first time, so we're very excited about that opportunity.

Also, we need to make sure that as we move to care management for all we do not crowd out all of the good care management strategies that are out there today. We are, in essence, doing an inventory of that. New York probably has more variation than most any place else. There are some people who do care management today who are going to have to do different things in the future. But at the same time, there's folks for some of our special populations, including programs like self-directed programs, which we have a very good program like that in New York, that we want to make sure that self-direction, particularly for developmentally disabled people, remains a part of the service array. And then, as I said, thank God we have three years.

So, with that, I'll open it up for folks, and follow us on Facebook and Twitter.

[Laughter.]

CHAIR ROWLAND: Questions for the panel from the Commission members?

VICE CHAIR SUNDWALL: The last thing you said, Jason, prompted me to -- did you talk about the dual grant that you received?

MR. HELGERSON: Oh, yes. So a number of states received dual planning grants. The idea is to basically gets states working together with the federal government and other key stakeholders to start

identifying new service approaches to basically better manage the services for dual-eligible populations. We're hopeful that out of that will also come new shared savings models for the population.

Right now it's sort of complex to try to really generate -- we have PACE models, but they tend to be very small. Actually, a currently of years ago, in an effort to try to encourage more fully integrated care management models, the state put a moratorium on the growth of partially capitated models where you just did the long-term care, the Medicaid portion. We've taken that off because we at least want to get everybody on the managed care side, on the long-term care side. But I think what we're hoping is that that grant and the conversation with the federal government is going to lead to some more creative thinking, because that's really where we think the money is for both us and for the federal government.

COMMISSIONER MOORE: Mike, and Jason, too, if you want to comment on this, there has been a certain amount of skepticism over the years with regard to PCCM programs, and some of them I think probably are open to some criticism for the fact that they just are kind of an extra payment to a primary care doc to make sure that that doc is there when someone needs them. But it sounds as if you have developed a very sophisticated approach and one which does, in fact, ask that practitioner to manage care, and I'd like for you to just say a few more words about what you expect. Do you sign contracts? Do you provide training? What kind of oversight is involved? And how would you differentiate your PCCM program from others in other states?

MR. FOGARTY: Thank you, Judy. Yes, it is a very sophisticated program, and it takes our filter about paying for what you get seriously. It is a formal contract. Our three tiers that are available to all PCCM practitioners are formalized in an agreement. And it involves very specific activity, things as concrete as extended hours, which is one of the basic early on -- I think it's a tier two.

There's a minimum -- I think it's four hours a week -- they have to demonstrate, and we will audit the availability of that. And it's not just that they're on call. They are in the building with the door open four hours beyond the normal 40.

So it is very specific. We have done and will continue to do a lot of training in the field with providers that are interested. I think the money's not insignificant. The range is -- I'm going to ballpark -- $4 to $9 per member per month depending on which tier. And it's monitored very closely. We try to use more carrot than stick, but we keep a stick handy.

It's not so much -- a lot is made of whether you're ultimately paying for anything on a cap basis as opposed to a fee-for-service. My experience is that that's not really what makes the difference. The difference is if the payment is tied to a behavior. If it's a capitation payment, it has to be tied to specific behaviors in order to earn that cap payment. If it's a fee-for-service payment, obviously there has to be a direct connection between what's done and what gets paid for.

So even when I use the term -- I think you could do a managed care program and not have any capitation. I mean, I think we too quickly define managed care as capitation, whether it's partial or total, it doesn't really matter. Managed care is the way service is delivered. It's not the methodology that it's paid for. That's one opinion.

There's a good comparison -- it was done, again, by Mathematica. It was done for CHCS. It compared five states -- it compared Oklahoma and Pennsylvania and North or South Carolina, Arkansas -- that I think has some good information you might be interested in. I know it's on our website. I'm sure it's also on CHCS' website.

CHAIR ROWLAND: Thank you.

COMMISSIONER CHECKETT: This is a question for either Jason or Mike, actually totally unrelated to anything you said, but we've had some discussions earlier today, some of the Commissioners, and looking at all the likely changes ahead of us in terms of how people will be accessing Medicaid, low-income subsidies, private insurance through the exchanges, there seems to be an implicit assumption that the majority of people who are trying to access coverage like that are going to be doing this through computers. And I'm wondering if you are aware of either personal -- either research or experience that you've had with your agencies or you've heard from other states. Does anybody really have a good sense about how available that technology is? Everybody keeps saying they can go to the library. Well, I have to tell you, there's a lot of people who aren't going to get to the library to get to a computer. Now, that I do know. So I would just be curious, or if you could direct us for someplace else to look.

Thank you.

MR. FOGARTY: I can do this very briefly, and I'm anxious to hear Jason's response as well. Our experience that tells me a lot about availability and access to computer is our online enrollment system, and I don't know whether you've tracked that. But I will tell you, we were amazed, positively, about the quick conversion when there were both systems available from either paper mail or office visit versus electronic online enrollment. Those numbers literally were shocking. And it has said to me access to that Internet is very, very available. Obviously, that doesn't meant 100 percent, but -- and I wish I could cite those stats. It is available on our website. It's something that we've -- I have trouble keeping my staff at home because so many entities are wanting to talk to them about the online enrollment system. But it has been overwhelming how successful that has been and how quickly the vast majority of renewals and new apps were converted to that online system.

COMMISSIONER CHECKETT: That's terrific. Thank you very much.

MR. HELGERSON: Yes, I can add to this question easier with my old hat than I can with my new hat because when I worked in Wisconsin, 60 percent of all incoming applications came through the Web. So it went from a period where it was sort of nascent at 5 percent, but as the tool became more sophisticated, as you encouraged more people, as time went on more people began to get used to it.

Now, those online applications are not just coming from individuals sitting at their home computer and filling them out. It's also coming from 200 community-based organizations who the state had trained to basically serve as entry points and that they worked with members. So it's sort of a mix of both of those. But the benefit of a simple, very straightforward online application tool is you could potentially empower thousands of other people to work with populations, you know, because it's not as hard -- you don't have to be an eligibility worker with 20 years' experience to help someone in Wisconsin sign up for an application.

Now, in New York things are not quite that way. We have very old systems. We actually have multiple systems. New York City has one system. The rest of the state has another system. I actually think the exchange is a golden opportunity for New York to really build a modern platform, to engage a wide array of stakeholders to assist in enrolling people both in Medicaid as well as in subsidized insurance through the exchange. But I do think it has to be almost like -- I hate to use this an example, but a thousands points of light or a thousand points of entry into the system of organizations all over the state potentially willing to work with people, and that potentially includes brokers, it includes human service agencies, and it includes community-based organizations.

COMMISSIONER CHECKETT: Thank you. That's really very helpful.

COMMISSIONER GABOW: I have two sets of questions. One is around quality, the other is around behavioral health.

When you talked, both of you, about incentive quality, usually that means there are 10 quality measures or 15 or 100, whatever. So can you say what has happened first to those measures over time? And, two, have you found that if you focus on those measures, actually other things go down? One of my objections about all these measures is -- you know, if you focus on hemoglobin a1c, great, you'll do that, but then you won't get your blood pressure controlled. So most of these measures are small dimensions of care rather than big.

Have you ever removed a provider from your network because of a quality measure?

MR. HELGERSON: I could start because I think I have slides here to show this. There are several slides. They're in your packet. But just on the quality measures themselves, you know, our experience in New York suggests that quality does improve; and if you look across the entire scope of the -- and these are HEDIS measures, and I want to preface it because HEDIS measures are helpful. They give you some sense of whether or not people are getting the services that they need. Do they tell you whether or not a diabetic has their diabetes really under control? No. And that's why eventually, hopefully, we'll get away from process-based measures, you know, that are like this, which look great, you know, women's health, series of measures, things improving over time. And I think if you look across the board, you will see that in a number of different areas we're seeing improvements.

That said, I think you're right, it's this balancing act where you don't want to ask them to do too many things. When you ask them to do too many things, they can't try to implement, you know, initiatives around all of them, and then as a result, whatever improvement you get is really random.

At the same time, you don't want to -- if you're focusing them on certain areas, which I would argue really should be based on an analysis by the state with its key stakeholders, what are the big challenges this population faces today? What are the issues that we want the managed care organizations to do, you know, short, mid-, and long term to assist this population, hold them accountable for those? Stay consistent in your measures. You don't want to switch back and forth too much. I mean, you hone it over time.

But I think also you always want to be looking at a broader set of measures, too, because if something else is going haywire in the population, there's another thing that's happened, you want to be able to address that as well.

So I think you have to look at the broad scope of measures, but also be willing to, you know, by population -- I think that's -- the other benefit is really designing programs specific to populations, and then identifying what that population needs and holding people accountable for achieving measures relevant to those things.

MR. HELGERSON: I'll say very quickly the answer is yes, we have terminated provider agreements due to failure to meet standards as measured by quality. And let me just quickly say that the favorite day of a Medicaid director is when the chief financial officer comes and says we are spending under budget, we have done everything we can think of to analyze why our projections were wrong and why we are spending fewer dollars than we budgeted, and our conclusion is it's because some of those things that we've incentivized on increasing quality and others, obviously -- access -- have actually begun to pay off, and that's why we're spending less money. And those numbers, I mean, we can back that up.

So I am enthusiastic about that. Measurement is critical. It doesn't hurt to share those savings

with the folks that produced those savings. But as I say, as much as we like carrots, the club is in the pocket as well.

COMMISSIONER GABOW: Can I ask my behavioral health question? How do you integrate, Mike, behavioral health in a PCCM program?

MR. FOGARTY: That's a great question. One of the criteria for our patients in our medical home is that they do screenings, including behavioral health screenings, and that they have resources available to refer those when those needs are identified. So a practice that engages in that is actually paid as part of their management fee for their commitment to do that. In fact, as I recall, that's one of the basic requirements even to qualify as a tier one medical home. That's number one.

Number two, I mentioned our health management has identified some 5,000. The largest percentage, the largest segment related to diagnosis of the enrollees that are in that health management program are people who are diagnosed with behavioral health. It's about 20 percent. But it's the largest percentage.

CHAIR ROWLAND: I think this panel has excited the Commission in a dark room today.

COMMISSIONER ROSENBAUM: That and the air having [off microphone].

PARTICIPANT: We complain a lot here.

[Laughter.]

CHAIR ROWLAND: It's too cold, it's too hot.

COMMISSIONER ROSENBAUM: So two things. One, I'd appreciate both of your views on whether you think ACOs add any tools to your armament that you might like to have. That's number one.

And number two, I'm very eager -- because both of you mentioned this, and it's one of the most

important things I think you both raised, about the effects of what you're doing on physician participation, and I'm wondering whether you can elaborate a little on primary versus specialty and whether you're getting more time from people who are already in the program or some entry for people who were not in the program before.

MR. FOGARTY: The short answer to the last question is both. I know you're not surprised by that. We track that every month, and we report on our provider contracting, and we keep that segregated in terms of PCCMs and specialty and all types of -- and you can see that record, and it's growing consistently. It grew this month.

COMMISSIONER ROSENBAUM: [off microphone] Primary and specialist?

MR. FOGARTY: Yes, yes.

COMMISSIONER ROSENBAUM: And a quick follow-up. The PCCM I sort of understand. The incentive is clear. What is bringing the specialists in in higher numbers?

MR. FOGARTY: A fair amount of that, I think -- well, number one, we raised rates across the board, so they all get paid more than they used to get paid. That's not insignificant. We went from about 71 percent of Medicare to 100 percent even though now we've dropped it back a bit.

The other is a lot of hand holding. I have full-time staff that do nothing but go into the field and recruit. That's what they do, just like you would see any MCO do.

MR. HELGERSON: Just in terms of ACOs, I think we are enamored by the concept, along with most everyone else in the country -- it's the shiny new thing everyone wants to talk about. But the question is: What is an ACO? And, obviously, the Medicare draft guidance has come out and generated a lot of discussion. I would say that most of the discussion in New York has been negative. There is a

lot of excitement in New York about the possibility for large hospitals or potentially even upstate New York with potential for hospitals to come together in new alliances that may be more possible before, new shared savings models and, you know, what that would mean. And I think that that the problem or the concern that we've heard from the New York hospitals is that the standards that are being set or suggested are so high that it's going to basically make it not relevant, and there are just other systematic issues. The hope, I think, is that those comments will be addressed, but definitely I think that's a potential.

The one area that relates to behavioral health is that behavioral health in New York -- Andy knows this full well -- has been probably one of the more controversial elements as it relates to the care management for all strategy. There's been a lot of resistance in the mental health provider community and the advocacy community about bringing behavioral health under the managed care rubric, particularly as it relates to insurance companies, sort of what we call mainstream plans.

What happened out of our redesign efforts was we ended up in an interesting place. The mental health community for the first time said, you are right, fee-for-service, not sustainable, we need something else; we like behavioral health organizations -- which to us is a major sort of step forward. It's beginning to acknowledge that your traditional system we've got to change.

But out of that discussion -- and the city of New York deserves a lot of credit for this, and the city is actually uniquely positioned particularly as a major provider of health care services through HHC – is that you have certain systems that are really ready and willing either as an ACO or as a SNP or as some other, you know, or as a plan, through a plan partner, to step up and take on a fully capitated arrangement. And I think that what we're hoping out of this three-year phase-in is we're going to end up with certain subsets of providers, probably some that are located in some of our most challenged areas in the state where

behavioral health is a huge problem, willing to take on full integration. There will be other parts of the state where we'll be having to basically try to coordinate efforts between two capitated initiatives. But, you know, I think it's a key challenge. If you really want to control health care costs for those dual eligibles, those highly acute people, you need to get at the behavioral health that's oftentimes driving the overall cost.

COMMISSIONER CHAMBERS: As my fellow Commissioners know, I can't help myself when it comes to dual issues, so I'm going to ask each one, and I'll give them both so that you have a chance to think about the answer.

Mike, purely just on the duals, you didn't talk about that so I'm just curious. Oklahoma is so different from New York, so I just would -- you know, in a different type of state and the challenges, I'd like you, if you could, just talk about that.

And then, Jason, you talked about PACE, and I actually had opportunities to visit a PACE program in Milwaukee last year. I think it's called Partnership, if I'm not mistaken. And one of their claims to fame was that they had been doing a PACE Without Walls program in Milwaukee. I'm just curious to know is now in New York is if you see -- anything you can say about that program.

Then the second piece of that for you, Jason, is I'm just curious if you're -- I work with a number of Medicaid-focused special needs programs or plans in New York, and I'm just curious if you think SNPs, you know, have an opportunity to serve the duals population and what New York's goals are going to be.

I'll let you guys go from there.

MR. FOGARTY: Okay. I'll run that line first.

We are one of the 15 grantees, recipients on the duals, and we're pleased about that, and we haven't had to turn that back yet.

[Laughter.]

MR. FOGARTY: I'm sorry to raise that.

COMMISSIONER CHAMBERS: Does the governor know yet?

MR. FOGARTY: Yes.

COMMISSIONER CHAMBERS: Okay.

MR. FOGARTY: And our grant contemplates really three tracks. One of those is a PACE. We have a very successful partnership PACE with the Cherokee tribe in Oklahoma that has really given us a lot of encouragement on the potential to grow that program, and I think that one is ripe.

The other one really plays out what I've said publicly has been a standing offer from Oklahoma to our federal partner now for at least 15 years, which is if you will just determine -- if we can jointly agree on the actuarial value of the Medicare benefit and you pay that to us, we will split the savings. And I'd even be willing to take the risk on the downside because I am so confident we could save that program. So that's number two.

Number three is a partnership that's really in the very early stages, but it's with the University of Oklahoma Medical School on the Tulsa campus, and it's part of their community-based -- what they call community treatment program. They've got a very active program now within the medical school, and they think that they could offer some sub-state -- this wouldn't be a statewide but a sub-state model that would coordinate benefits one way or the other. It's still pretty wide open. But they're a pretty creative group, and I expect to see some pretty exciting things out of them.

MR. HELGERSON: Okay. First, in terms of PACE Without Walls, I think we're open as we move forward to a variety of different models of care management for dual eligibles, and I think, you know,

PACE is a model that we'd like to expand, and the question is how you successfully expand it. And I think we need to look at variations on that model, and I think the PACE Without Walls program in Milwaukee is potentially a model for us to look at. So I would say that we're very open to that.

Then SNPs, you know, I think that New York has some important lessons particularly as it relates to SNPs for certain populations. I would say probably the population and the programs -- one of the things I'm most impressed by coming to New York is the programs for people with AIDS and HIV. New York, and New York City in particular, was to a great extent -- or was one of the ground zeroes for the AIDS epidemic in the 1980s, and New York probably invested more in trying to meet the needs and trying to figure out how we can stem this disease and meet the needs of this very sick, very frail, very challenged population. And there's a number of very successful AIDS/HIV SNP programs, so I think that there's a lot of lessons to be learned from the evolution of some of those programs and how they got to be what they are today that we need to learn from as we begin to look at other special populations.

We will not have the same amount of resources probably that were available at that time because of how much interest there was in the issue, and appropriately so. And we don't have as much time, or we don't want to take 15, 20 years to get to where they are today.

So I think we're going to have to use those successful models as a way to sort of jump-start our efforts as we get into populations like TBI and some of the other, you know, developmentally disabled populations. You know, we also have a lot of issues there, unique financial challenges there with our DD population.

So, you know, I'm hopeful that the SNP experience in New York will be helpful for us.

COMMISSIONER MARTINEZ ROGERS: He actually already answered the question I was

going to ask about behavioral health.

CHAIR ROWLAND: Okay, good.

COMMISSIONER COHEN: I think this is most relevant for Jason, but it is for you, too, Mike. I would love it if you would just walk us through, maybe map out for us a little bit what you have to do with CMS in order to implement some of these changes. I happen to know that the expansions into managed care come in a variety of different shapes and sizes. Sometimes it was a population that was exempt from managed care. Sometimes it was, you know, one that was excluded. Sometimes it's a whole new specialized program. The state has long experience with managed care, and I'm just curious if you can sort of lay it out for us exactly what you need to go through in order to get approval to do these different things and how many different categories and how extensive the work is to do it and how different for the different kinds of populations. Then, of course, any comments you want to make about whether or not it's a -- which part of the process is valuable and if any parts you think are not.

MR. HELGERSON: All right. In terms of CMS approval, that's one of the biggest challenges that's on my plate today. The Medicaid redesign team recommended 79 distinct proposals to save $2.3 billion of state share, so almost $5 billion of all fund spending in the Medicaid program in New York. That ended up going into 73 proposals between now and implementation. Those 73 required 34 distinct state plan amendment changes, and then there are also waiver changes to accomplish all those.

When I got to New York, we had a backlog of about 70 state plan amendments that were sitting in some stage of approval, including some that were sitting for years. Some date back as far as 2007.

So what we've had to do -- and I give Cindy Mann a lot of credit for this -- we really had to re-engineer the nature of the state of New York's relationship with the federal government, and now we

actually have a point person that's been assigned by CMS, John Guhl, who is a former Medicaid director from New Jersey, who all he does is work on Medicaid redesign team New York coordination for all that's happening.

So we've really, in essence, changed our relationship with them out of necessity, and I think as we move forward with our care management for all strategy, that's going to be the same case.

A number of the changes we need to move people from the voluntary situation into mandatory, in essence, require waiver approval. We realize that some of these populations are going to generate a lot of questions, so we're in the process of actually formulating the waiver requests. Even though some of this, like the mandatory managed long-term care, does not go into effect until 2012, we're already putting together the actual waiver request for that particular change because we know it's going to generate a lot of questions.

In some cases, for some of these populations, at this point we're not even sure exactly what that requirement would be. We've set up a three-year goal, but we're going to need the federal government to be willing to, you know, take a leap of faith with us with some of these populations. And certain populations are explicitly excluded, you know, for instance, tribal members, you cannot require them to enroll in managed care. But, you know, we're hopeful. We have states out there already enrolling people. You know, Arizona, the entire population is enrolled in some kind of managed care. North Carolina is the same way. So I think there's already some states out there who are doing it, but, you know, there's going to be a number of different things we need to do to get the federal.

CHAIR ROWLAND: Mike, didn't you say that you have your Cherokee tribal members enrolled, or not?

MR. FOGARTY: Yes.

MR. HELGERSON: But that's not managed care. I mean, HMO --

CHAIR ROWLAND: It's not a risk plan.

MR. HELGERSON: Yeah, and I think it's -- you can do it with -- you were able to do PCCM on a mandatory basis?

MR. FOGARTY: Yes.

[Inaudible comment.]

MR. FOGARTY: Probably, but, yeah, we've had pretty good luck. I will tell you, the thing that has complicated our life in terms of our relationship with that particular population is no co-pay rule. To have to redesign a system to treat that population differently on the co-pay, I mean, it sounds easy. It's very complex because in many instances they're seeing the same provider. So you have to re-educate the provider network and the systems have to accommodate. On this claim we're going to deduct the co-pay. On the claim that comes in from the same provider who saw a patient the same day, you can't -- you have to pay the full. You can't deduct the co-pay. So it's little things like that. Sometimes I worry that not a lot of thought was given to that. And I know that's not a CMS call either. I think that one came out in the statute.

And my answer to you is it depends on which CMS you're talking about, and I will tell you -- and Jason's got the answer. Find somebody, make so much noise that you get somebody who will be assigned to cross those silos. And this really is not intended to be a criticism, but the fact is you can -- if you have exactly the same request to modify a provision of the waiver as to modify a provision that applies to a state plan, you are dealing with two completely different bodies of people. They process it differently and --

because I'm sure different rules apply. But the fact is you can't assume because you got one done last month on one side that you're going to move quickly through the other side because there's no -- they don't share that. At least it doesn't feel like they do. And, obviously, the CMS today is not the same CMS that we dealt with three years ago.

COMMISSIONER SMITH: Jason, I had a question about what I think is a staggering number of plans within New York State, and what I'm wondering is twofold. I'm assuming that each beneficiary does not have that to wade through. Approximately any given beneficiary both in just the general sector and also in special needs, how many plans would they have to navigate and choose from, or can they choose from them? And, also, do you know what your default rate is for that? How many either don't choose either on enrollment or on renewal?

MR. HELGERSON: The statistic -- actually, Andy might know the answer. How many plans in the city of New York? Ten? Yeah, that sounds right. So about ten different choices in the city of New York. I think most all of them are, you know, five-borough type offering, but in terms of -- so that gives you some -- that would be the extreme case. So on the long-term care side, chances are that, you know, there are sort of fewer choices. But, yeah, it's -- off the top of my head, I don't know what the default rate is. I remember the statistic from when I was in Wisconsin because we did an RFP, a special procurement in the southeast, and we looked at the default rate of the past, which had been about a quarter of people basically are auto-assigned because they didn't choose. And we worked very hard and created all kinds of processes and calling and different efforts to raise awareness and advertising and things like that to keep that rate lower. And so we were able to come in I think about like the 12-percent range.

The other thing in New York that's different that I wasn't used to was actually we had what's called

facilitated enrollment in the sense that health plans get paid to actually sign people up, which is a different phenomenon. In Wisconsin, health plans were not allowed whatsoever to enroll anyone into the Medicaid program. They were explicitly excluded. And in New York, that's a very different situation. It has its strengths and its weaknesses, but in an environment where we do not -- we have very antiquated eligibility systems. It's another set of people out there to help at least get folks enrolled into the health care benefits to which they're entitled.

CHAIR ROWLAND: Robin, you can follow up.

COMMISSIONER SMITH: I do. I have to follow up. I hope I'm not stepping in a pile here, but do the beneficiaries know that?

MR. HELGERSON: In the sense of?

COMMISSIONER SMITH: That the care plans get paid to sign them up.

MR. HELGERSON: To the extent -- I would say probably most members --

COMMISSIONER SMITH: My son is a beneficiary --

MR. HELGERSON: -- would be unaware that that's the case. I mean, it's like anything. You see -- I mean, it's an interesting phenomenon. It's something that I was not used to. I live across the street from a park that had a festival recently, and I walked in the park, and there's one of our health plans in essence marketing to people attending this thing, Sign up for our health plan, sign up for the Medicaid program, are you uninsured? You know, it's a two-edged sword there in the sense that, one, you have to get people signing folks up, and then, second, the question is, is there a conflict there in terms of -- you know, and we've had some practices. The city of New York was the entity to contract with the state to try to make sure that some bad practices -- and my understanding is there were some pretty bad practices in the

past that need to be prevented. But when you do have plans and you engage them in this effort, there are potentially downsides that you have to heavily enforce.

CHAIR ROWLAND: Robin, if you want a little history, the original regulation of managed care plans in California came because the plans were out marketing themselves to consumers, and they were offering TVs and chickens to people who would sign up with their plans. So that's the beginning of the regulation.

MR. FOGARTY: And that's not unique to HMOs, by the way, let me just say. Individual providers will market as well.

CHAIR ROWLAND: Will do the same.

MR. FOGARTY: And just gratuitously let me drop one more pearl. Auto-assign is the bane of PCCM programs. Auto-assign -- and we've got scars to prove it. You can't make selection of a PCCM an eligibility requirement. You might, though, have a field on the online enrollment form that is a mandatory field that has to be a physician or a PCCM practitioner if you were really risky, which we did. So that worked pretty well. But our experience with auto-assign, that is very bad policy with regard to PCCM programs.

COMMISSIONER CHECKETT: Because you're assigning someone to a physician.

MR. FOGARTY: Right.

COMMISSIONER CHECKETT: Really. And I want to just clarify that because that was my experience running the health plan, is that it was much easier to get people assigned to us, but when we tried to do an auto-assign to a doc's office, they inevitably called us back and said, "I don't like that doctor. What are you doing?"

MR. FOGARTY: You can live with it with a plan, and we did both. But with a PCCM, our experience is you can't, neither on the provider side nor on the enrollee side. They're always surprised. It's never convenient. It's just --

CHAIR ROWLAND: It's just bad.

MR. FOGARTY: It's just a bad thing. A bad thing.

COMMISSIONER HENNING: I'd like to hear actually from both of you how you treat maternity care under your programs. Is that considered a special carve-out since that's the population that accesses care very frequently in a nine-month period. And, also, when you're paying for performance or, you know, paying for outcomes or whatever, have you looked at paying more for vaginal delivers versus C-sections, maybe paying more for VBACs versus just elective, you know, scheduled C-sections? And are you currently doing that?

MR. HELGERSON: All right. I'll take a first shot. It is a carved-in benefit. It is not carved-out maternity care. Interestingly, we as part of the redesign team had initiatives specifically around changes in payment rates for unnecessarily -- and always hard to define -- C-sections, basically tried to drive down the C-section rate. We're spending a lot of time with the industry, the hospital industry, trying to figure out how to measure it. Actually, one of our hospital associations came up with what we thought was a pretty good measure. They then took it back to their clinician community -- hospitals in New York employ a lot of physicians, particularly obstetricians -- and got immense pushback from the obstetrical community about how you can really measure whether -- and even whether or not C-sections are inappropriate, even though there's a lot of research. There's a huge amount of work we in New York I think have to do around how to engage the physician community around C-sections.

But in Wisconsin, absolutely, we did an efficiency adjustment with the managed care companies because when we looked at the data, the variation across the state for C-section rates was tremendous, and it was interesting because most of the time folks thought in Wisconsin that you had Milwaukee in the southeast where you had very poor, urban poor populations, where generally most health statistics were worse, and it was actually the reverse. The C-section rate in southeast was much lower, lower than the state average, but in other parts of the state, you had much higher C-section rates.

And when we asked the plans who contract up there, they said, you know what? It's right. We're not doing a good enough job. We need to focus on it. And they actually didn't complain when we adjusted their rates because they thought that it -- basically for the care management staff, it would be a further tool for them to go back to their organization and say we need to do something about this because we are now taking a hit financially because we cannot get our docs to work with us.

MR. FOGARTY: And, of course, carve-out is not an issue for us because we pay fee-for-service for those benefits, anyway. So maternity services are paid fee-for-service.

I would add that on our care management side there is a very proactive care management function that goes out to every identified -- any pregnant woman in Oklahoma, once certified on the basis of pregnancy, there is an outreach to them because we make a very early determination in all cases possible of any high-risk factors that are present.

We also ran into the same -- we ran into the buzz saw on the C-section, although ours ended up being a compromise. We're going to be working very closely with the OB/GYN community in Oklahoma. I think we'll succeed. We've got a malpractice situation. I know it's not unique to Oklahoma as well, particularly on the VBAC situation, where no OB/GYN can afford to not do a C-section

just because of the coverage issues. But we're going to make progress on that. But we just merrily ran directly into that one by suggesting that we roll back our C-section payment based on any documentation that it appeared to be a convenience C-section as opposed to a medically necessary one. Easily said. Not easily done.

CHAIR ROWLAND: And you do enrollment for pregnant women at physicians' offices as well, right? Isn't that part of your --

MR. FOGARTY: Anywhere they can access an Internet.

CHAIR ROWLAND: Anywhere you can access them.

MR. FOGARTY: Anywhere they can access an Internet.

MR. HELGERSON: Yeah, I think that is a problem within managed care that we have to think about how we address, which is too often women sign up, you know, the end of the first trimester, and, you know, most states -- New York is no different than this; Wisconsin's moving away from this -- you sign up, you're enrolled in fee-for-service, there's a process, you're mailed a packet, you're assigned. But sometimes that -- you know, you're into the HMO, but by the time the health plan realizes, you know, they don't have enough time to do the kind of intervention necessary to get you the services, and then, unfortunately, sometimes you end up with a bad birth outcome. So I think we need to think about how we can get those women into effective care management strategies faster.

CHAIR ROWLAND: Or getting them covered before they get pregnant.

MR. HELGERSON: Or that's even better.

MR. FOGARTY: Or that.

MR. HELGERSON: Yeah, because particularly for women who've had bad birth outcomes, that

inter-conception care is so important. We have to make sure that we don't have disruptions in coverage and that we get those women enrolled long before they ever get pregnant.

COMMISSIONER EDELSTEIN: Mike, in Oklahoma, what is the responsibility of the primary case management function with regard to oral health services? Or does the dental system ride along in parallel with it?

And, Jason, as you do the redesign in New York, what's the anticipation of involving dental providers under some kind of a managed system given that there's so little managed care engagement by the dental community?

MR. FOGARTY: Great question. We continue to attempt to integrate those two, you know, by doing some preliminary -- particularly on the pediatric side. We've had more luck there doing some initial screening and even treatment. And that one, we're making some progress on that. We're not where we need to be yet.

We're happily seeing impressive increases in the number of people accessing our dental benefit, and I think, just intuitively, not data driven, but I think that that reflects some of the work that's been done with those PCCM providers. If they do nothing else, they at least encourage that family to get access to that dental care.

MR. HELGERSON: In terms of dental, I think one of the challenges -- and all states are in this situation -- is capitation creates financial incentives to control utilization. The issue is that -- and this is why you can't just turn the money -- turn the people over and then sort of look the other way, particularly in areas where lack of utilization is a problem. And I would put dental right now as an access issue sort of at the top, but behavioral health not that far behind. And so in those areas, particularly for us upstate, we

have dental access issues that are common. New York City is a little bit of a different situation, but I think what we need to do is, as part of the contract with these plans, we need to look to make sure that we create financial incentives, not to inappropriately control utilization, in fact do the reverse. And that was one of the things that when we had -- in Wisconsin, we had a big decision to make about when we did this procurement, were we going to carve dental out? Were we going to carve it in? How were we going to do it? We decided to carve it in but to actually build in a higher capitation payment, assuming higher utilization, and then actually putting in fines, in essence. So if you failed to show growth in utilization for the population, there were specific financial penalties built into the contract.

So the idea is we know and acknowledge that more dental utilization is needed. You need to go out and make sure that happens. And if it doesn't, we're not going to let you pocket the money. And I think that, you know, that's a strategy. It will be interesting to see how that plays out in the greater Milwaukee area in Wisconsin. But, you know, I think that's one of those things where you do not want to -- if you just let the normal process play out, you know, you have, I would argue, misaligned incentives there that will work against you in the long run.

COMMISSIONER RILEY: You're great leaders and I think have done wonderful stuff to overcome lots of barriers to get to great Medicaid managed care, so I'd like to suspend reality.

[Laughter.]

COMMISSIONER RILEY: With the exception of more money -- you can't list this -- if you were given the magic wand and could do anything to overcome policy barriers, regulatory barriers, political barriers -- it's the magic wand -- what would it be to make sure that really great Medicaid managed care happened for all populations?

MR. HELGERSON: Interesting question. Actually, I'll answer it this way. I'll give Mike a little bit more time to think.

MR. FOGARTY: Thank you.

MR. HELGERSON: You know, it's funny. I sometimes have to -- and Andy being involved in this knows full well, but you look at the final outcome of our approved plan for three-year phase-in of mandatory managed care. There are lots of moving parts in this proposal. There was a tremendous amount of negotiation that had to go on between a wide array of interests, right? And the issues are that as you dig deeper into this, as you actually start getting serious about trying to get Medicaid out of the fee-for-service system, you start unraveling all the different interests who have a stake in the current status quo.

So there's a couple of choices, and kind of the choice that a lot of people do is, okay, we're going to try and smash through the opposition. We're going to use whatever political force we can. We're going to try to line up the votes. It's going to be ugly, but we're going to try to gain success.

Our approach, Governor Cuomo's approach, was to try to get the stakeholders around the table, in essence, and negotiate a path forward. It was a challenging negotiation. You don't end up with everything you would possibly like. But I actually think that what you end up out of this process, hopefully, is a lot more stakeholder buy-in to it. And in New York, it's probably more complex than virtually anyplace else. I only have one other state to compare it to, but it's a lot more because, in addition to you have local units of government, you have big providers, you have smaller providers, you have unions, you have health plans, you have advocates, you have a whole series of groups, and even within -- you know, behavioral health was a major challenge for us. But I actually think at the end of the day that we're better

off having gone through that process. And so my only fear of getting the magic wand is that you'd go to the path of least resistance, enact what you think is your dream model, and lose out on what was, I think, a rich perspective from all these different stakeholders.

But I think at the end of the day, yes, there will be some bumps in the road, yes, there are going to be some challenges in implementation and further negotiation. But when we look back in five years, we'll end up with a very unique model that will have balanced these very reasonable perspectives in what is otherwise a complex discussion. And hopefully at the end of the day everybody at least felt like they had their say, and that we'll all feel like we had some impact and be supportive of the final result.

COMMISSIONER RILEY: Would the stakeholders have come together the way they did without Governor Cuomo's leadership, they knew he was serious?

MR. HELGERSON: I think what they realized was that the budget situation was very serious, that there was no way we were going to tax our way out of it. I think that there was -- and that I think was leadership, and leadership from governors is absolutely essential. And I think what happened was that -- I don't know what Andy said, but there was a lot of talk about the millionaire tax in New York, which was a tax that was going out. But what people realized is that the governor proposed $2.3 billion in cuts in Medicaid and a comparable number in education. The millionaires' tax only generated about $1 billion. So there wasn't enough money from that one taxing source to make up for it all. So there wasn't some silver bullet solution to this challenge. And I think when people got serious about that was when the stakeholders came together and said, okay, we're going to have to take this money out of the system, how do we do it most effectively?

MR. FOGARTY: Thank you for the time. It helped.

I mentioned that, for all practical purposes, we're running a statewide MCO. That's what we're doing. In order for that to work, there are two or three things I think we need.

One is I need to be able to enforce primary care selection. It's impossible, in my opinion, to have an effective managed care organization if you can't get a care manager at the front end via a primary care practitioner. So I need to be able to do that. It's not too burdensome. Obviously, I have to make it doable. I have to make it friendly and easy for somebody who has no clue to be able to make that selection. But it's better than auto-assign. And we need to be able to do that.

Secondly, it's health care, not welfare. We're talking about people in Oklahoma who make at or above the median income. I need to be able to use co-pays in a responsible way to reinforce appropriate access to providers -- ER utilization, for example. I need to be able to -- by putting a financial stake in that, for at least some of the population. I understand. To the extent we're still dealing with the old -- what too many people still think of as the Medicaid population being absolutely destitute. But to the extent you're not, which we're not in a big way, I need to be able to use some co-pays as a financial stake that direct people to make the better choice. And I use the ER as an example.

I need to be able to lighten up benefits on some of these. I need to be able to not have non-emergency transportation as a mandatory service for my total SoonerCare enrollee population.

I think I could manage even benefits to children that would probably fall a little short of the current EPSDT requirements that say if somebody says they need it, you got to do it. I need the ability to say no, not so much, that's -- we're not going to go with it just because somebody said it.

So those are things that just come to mind.

VICE CHAIR SUNDWALL: I can't resist this follow-up. It's just the perfect segue. Would

you please comment on the current legislation to repeal the maintenance-of-effort requirement?

MR. FOGARTY: Oh, man.

[Laughter.]

MR. FOGARTY: You were talking to Jason, right?

The maintenance-of-effort requirement has in some ways served us well because it has deprived us of what would otherwise be the easy answer.

UNKNOWN SPEAKER: [off microphone] what you just said.

MR. FOGARTY: Well, no, I'm not saying that we could just arbitrarily take people off the roll. I'm saying that we ought to be able to lighten the benefit, or we ought to be able to have them put some more money in the game.

As a true, you know, state person, we think we would make -- I think we would make the right decisions, but I think the maintenance-of-effort requirement in some respects has done us a favor by taking that arrow out of our quiver.

Here's what it means. We're among friends. It means that about the only way I can reduce spending is to reduce provider rates. That's about where we are. They are tremendous allies in the competition that goes on in terms of resources to support the program.

I don't think that eliminating people from the program has the kind of political strength that provider rates has when it comes time for the state to make those -- so as the person that's wanting to protect this program, I'd rather have the provider standing next to me saying you can't cut rates than to have a bus full of folks saying you can't cut me out of Medicaid, just because of the reality that that's -- the providers will have -- they will get the job done, and have, and the record I think speaks for itself if you look

at what's going on in states on these decisions.

MR. HELGERSON: As somebody who spent most of the last four years on somewhat of a singular mission to try to cover as many people as we possibly could in the state of Wisconsin and created a whole series of programs to try to get to 98 percent of the citizens of Wisconsin having access to insurance and actually potentially being enrolled in some kind of insurance, it was very important to me that, as I was leaving Wisconsin, I would take a job somewhere else where those values were important. And moving to New York, I moved to an environment where never once during our discussion with regards to the Medicaid redesign team from the governor on down did anyone seriously consider eliminating, taking away coverage for individuals in the program. Even if we hadn't had maintenance-of-effort requirements, I really think that that would not have been part of our debate.

I think what everyone said was that the state has a moral obligation to help its citizens who are less fortunate. The question is: How do we do that as cost effectively as we can? And that was really what the focus of our discussion was.

So for me, in my job, the whole MOE requirements really have not had much impact on our work.

CHAIR ROWLAND: And that really is where we are today, looking at how to make the program work better. That's why our focus in this report is going to be on managed care, on how to handle better the services to the population that is being served by Medicaid today, look forward in the next few years to how that's going to evolve and how to put it together. I think you've seen a lot of interest of the members of the Commission in looking at the PCCM model. One of the reasons we held this panel today was we were really focused in our last discussion on the risk model, and we wanted to get more information on how a PCCM model could work.

We see that, you know, when you do it -- one of our mottoes now is when you do it well, it's well done. And I think both of you are very great examples of states that have a hand on the pulse of trying to make the program work better and more cost effectively but more quality effectively as well for its population. So your comments today and your comments in the future, since you are not going to escape from our purview, are really going to be helpful to us in shaping our report and in shaping our future work.

And so I want to thank you for coming and just offer you one opportunity while you're here, if there is something you think we at MACPAC could be looking at or pursuing beyond our initial report, you don't need to comment today, but if you could get back to us, because we're really trying to look at what our research agenda and what our policy and analytic agenda should be in the future, and if there's ways that we could be looking at these issues that would be helpful to you in your design and on-the-ground efforts, we'd be glad to do that.

MR. FOGARTY: Great. Thank you very much.

MR. HELGERSON: Thank you.

CHAIR ROWLAND: Thank you.

We'll take a five-minute break. Five. We know that means ten, but five we'll start with, and then we need to get back to managed care.

[Recess.]

OVERVIEW OF DRAFT CHAPTER,

"MANAGED CARE IN MEDICAID"

CHAIR ROWLAND: If we could start to reconvene, please?

Well, as I said in our opening, our intent for our report to be delivered in June has been to really

take on the issue of managed care, to look at the role managed care is playing within both the Medicaid program and the CHIP program as part of our mandate to look at how the Medicaid and CHIP programs are intersecting with developments in the rest of the U.S. health care system.

So I'm going to ask Lois Simon, who has led the staff effort here, to do an overview of where we are with our report and open it up to a broader discussion from the Commission members.

* MS. SIMON: Okay, great. Managed care and Medicaid. The draft chapter before you is designed to provide a broad overview of managed care and Medicaid --

CHAIR ROWLAND: Lois, you might need to pull your mic a little closer so that we can pick you up.

MS. SIMON: Is that okay?

CHAIR ROWLAND: Yeah.

MS. SIMON: Okay. -- and it will present MACPAC's policy and research agenda for future work in managed care. So I really look forward to your comments and the discussion following kind of the brief outline of the chapter.

The Commission has chosen to focus their June 2011 report to the Congress on Medicaid and managed care for a number of reasons. First, MACPAC's authorizing language directs the Commission to focus its June report on issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the U.S. and in the market for health services.

Managed care is the delivery system of choice for not just most insured Americans, but also for a majority of state Medicaid programs. Almost half of all Medicaid enrollees, mostly children and non-disabled adults, were in risk-based managed care in 2009.

Also, as states seek to control costs and better coordinate care for their Medicaid populations, it is expected that they will expand their managed care programs to populations historically excluded or exempted from managed care, and these are mostly higher cost, higher use enrollees, people with disabilities and those over age 65.

Further, according to current law, changes in Medicaid eligibility in 2014 will result in additional persons enrolled in Medicaid and CHIP and states are likely to rely on managed care for these populations.

Earlier this afternoon, I outlined the Commission's work over the past months on managed care and a big conclusion was that there's a lot that we don't know. Overall, research findings on access, quality, and cost savings are mixed and dated, and also there's little research on how well managed care works for the disabled and dual eligible populations.

As I stated earlier, most states seem to be considering extending managed care to people with disabilities and their dual eligible populations. So Section B of the chapter focuses on enrollees and enrollment in Medicaid managed care.

After an overview of the populations currently enrolled in Medicaid managed care, the section moves to a discussion of the SSI population, focusing on state rationales for pursuing managed care for this population, and discussing the challenges and issues that must be addressed when implementing programs for a population with diverse health needs and characteristics.

The section also discusses the dual eligible population and highlights two fully integrated managed care plans for dual eligibles, the PACE Program and Special Needs Plans. And lastly, the section closes with an overview of the enrollment process and the importance of communicating and educating enrollees on how managed care differs from fee-for-service.

Section C of the chapter provides an overview of the three main types of Medicaid managed care models as used in the CMS Medicaid managed care enrollment report, risk-based models, Primary Care Case Management, or PCCMs, and limited benefit plans. Using this definition, 71 percent of Medicaid enrollees were in some form of managed care. And breaking down the data, 47 percent are in risk-based managed care with another 14 percent in PCCMs.

Blending these three diverse managed care types fails to capture important differences across states in the scope of their managed care programs. For instance, the inclusion of limited benefit plans -- and these are plans that typically provide a particular service or benefit such as transportation or mental health -- can lead to duplicative counting, and it also suggests that states with little or no risk-based managed care have high managed care penetration rates.

The section also details the two types of risk-based plans enrolling Medicaid enrollees, commercial plans and Medicaid dominant plans, and provides an analysis of the Medicaid risk-based market by firm. A discussion on states' decisions to carve out certain services or sub-populations follows, and while what is carved out very substantially across states, the most common service carve-outs are for behavioral health, dental care, prescription drugs, and transportation.

The section concludes with a description of the key functions that states generally include in their contracts with participating plans.

Section D provides a statutory and regulatory overview of Medicaid managed care payment, highlighting the regulations requiring states' capitation rates to be actuarially sound. It describes the three main approaches to managed care payment, with the most common being administered pricing where capitation payments are determined by the state and plans are free to choose whether to participate.

It explains how plans establish rates and discusses the concept of risk adjustment, which are just rates based on enrollee health status, to better reflect the mix of enrollees in each plan. And lastly, the section discusses some of the risk-sharing arrangements that states have instituted in order to share some of the risk borne by managed care plans.

Section E highlights findings from a review of the literature on access to and quality of care in Medicaid managed care that was first presented at the December Commission meeting. A key finding, which I mentioned earlier, was that most research on the topic is dated and results are mixed, reflecting differences across states, markets, and metrics used for comparison.

And establishing provider networks for specialists seems to be a larger issue than for primary care physicians. And this is a finding that came up both within the literature review as well as the round table discussion that MACPAC convened in October. We also highlight how managed care changes the way enrollees get their care, introducing concepts not prevalent in fee-for-service such as care coordination and preventive care.

Also, managed care may require enrollees to select a PCP and obtain prior approval for certain services, again, features that are not common in fee-for-service. Moving to quality, we highlight the quality measurement monitoring and improvement activities most commonly used in managed care.

Section F has three components. The first component describes the Federal and state requirements for Medicaid managed care programs and plans. The second component, program integrity, provides an overview of the Federal, state, and plan requirements and efforts towards preventing fraud, waste, and abuse from occurring, and for ensuring that payment for services is proper and appropriate.

And the third component describes the data the plans submit to states and states report to CMS on

enrollment, service use, and spending. We also raised issues related to the variability across states with regard to consistency, availability, and timeliness of data.

The final section, Section G, outlines the Commission's agenda for moving forward in the area of Medicaid managed care. The focus is to gain a better understanding of Medicaid managed care today. Then have the ability to evaluate trends into the future and develop policy options that can further the goals of managed care and improve the experiences of Medicaid enrollees.

So I look forward to your comments and discussion on the chapter, especially, I guess, the tone, the direction, and just your overall thoughts. Thank you.

CHAIR ROWLAND: Thank you, Lois. A stunned silence. Judy.

COMMISSIONER MOORE: In light of listening to Mike and Jason, one of the things that I feel a little bit is missing is -- and I don't know how to articulate this. I will leave that to the staff. They do such wonderful work for us all the time. The difference between managed care and care management. I mean, the fact that you can have a managed care program that doesn't really amount to much in terms of beneficiaries getting good coordinated care that's well managed, help them find their way through whatever the managed care system is, whether it's PCCM-based and help finding specialists, or whether it's a closed panel system.

But I'm not sure that we've reflected that as well as perhaps we could. And I think their comments about how much -- how much state oversight and planning and work has to go into that, how many state resources have to be devoted to that are important to reflect in the report as well.

CHAIR ROWLAND: Especially for the discussion of cautions moving forward, that it requires planning and time which Jason so well put on the table.

COMMISSIONER MOORE: Right. Well, and also especially in terms of the fact that the population groups that most states seem to be talking about serving to a greater extent are people with disabilities, duals, elderly people, and people in managed long-term care, which is a newer phenomenon than managed acute care.

CHAIR ROWLAND: Sara, Burt.

COMMISSIONER ROSENBAUM: Just a note that the other thing I think we probably want to make special note of under Section C is essentially what Oklahoma does, which is to say you know a state doesn't have to buy, a state can make. A state can essentially be its own managed care entity, in which case it's running a network, it's doing all of the things that a private contractor might do, and there are -- I remember a long time ago having a discussion then with Bruce Bullen way back in time in Massachusetts about the fact that that was what Massachusetts did as well.

So I think highlighting that, you know, noting that this is a strong possible model is important.

CHAIR ROWLAND: Burt.

COMMISSIONER EDELSTEIN: Building on Judy's observation, I think that Jason's remarks with regard to using management techniques, contracting and incentives and management techniques to actually improve a service that is flagging is something that we hadn't considered in our drafting so far.

Most of the effort in managed care has been about controlling inappropriate or excessive utilization, and we hadn't highlighted the potential, as Jason did, to utilize managed care contracting and incentivizing plans to turn that upside down and go in the other direction.

And I think that if we were to insert that into our report that it would provide some assurance to those who are in the fields of oral health, behavioral health, and some of the other areas that have been

chronically problematic, and where the communities have terrific concerns that things will only get worse under a managed care program.

CHAIR ROWLAND: Well, certainly in our discussion where we talk about behavioral health and we talk about oral health to reflect some of Jason's comments about that strategy would be very helpful, I think.

COMMISSIONER EDELSTEIN: And in our reports so far we've been looking at those services primarily through the limited benefit programs, limited benefit plans. And Jason's comments opened the opportunity to have real integration with the full risk plans. And that also opens another opportunity for oral health integration with overall health.

For example, in those few remaining states that have robust adult Medicaid programs as an option, like New York does, there's a real potential for dentists to do case finding and screening for diabetes, for hypertension, for -- even for HIV; for dentists to also contribute to common determinants of health through tobacco cessation efforts or nutrition counseling, which would reintegrate the oral health component of people's health care into a system of care that puts the mouth back into the body.

CHAIR ROWLAND: Okay. Patty was next.

COMMISSIONER GABOW: I don't think I can follow the last comment, but -- no, I don't think so. But I think the other thing that Jason pointed out, and Mike pointed out in somewhat different ways, which we really haven't discussed at length was how they interface between the states and CMS can enable them to effectuate change more rapidly or completely.

Mike was saying that for ten years, they've been trying -- they've had an offer on the table to do this blend and can't do it, and Jason, having some papers that date back to 2007, without sort of -- I mean, we

understand how complex it is and how much CMS has on its plate, but in an era when things are changing very quickly, we expect people to innovate quickly, and there is a need to innovate quickly from a financial and a health care delivery model.

I think some discussion about are there better ways to facilitate this in some way that might have some utility, or at least we should phrase that as something to be considered.

CHAIR ROWLAND: Or even how it relates to the teams that CMS is now sending out to help states with their cost containment efforts. I mean, is that also helping them to streamline some of these things? Andy. David, I'm sorry.

VICE CHAIR SUNDWALL: I keep getting ignored here.

COMMISSIONER COHEN: Go ahead.

VICE CHAIR SUNDWALL: I don't get hurt in her line of vision.

Just a quick comment. You asked for what we thought of the tone of the report. I think it's great because of the overall enthusiasm I see for managed care. I mean, it seems like, as we've mentioned, this is where we seem to be going. In a conservative state like mine in Utah, there's enormous faith being placed on some waiver that's going to save a lot of money if we can only get more people in managed care.

So I think the report, as I understand it and as we've discussed it, is really balanced. It's not really bullish on managed care, because -- not because we wouldn't necessarily be enthusiastic about it, but because we admittedly don't know enough to be strongly endorsing these programs. I think that does the states a service if this will be utilized because instead of rushing straight into this, they'll maybe give some thoughtful consideration of, are these alternative delivery models or something else?

So I think it's going to be very useful, and it's certainly timely given the interest at state level, and

certainly the Federal Government as well, to get more people into managed care.

CHAIR ROWLAND: Andy, then Richard.

COMMISSIONER COHEN: I just wanted to follow up on Patty's point, and I think that maybe one other point we can highlight a bit more in the report is just -- I mean, obviously, we sort of highlight Sara's great term, sort of the evolution, and we really are evolving into a world that is so heavily, on managed care, we're there. We know some things. We need to know more things.

But I think the sort of like statutory basis has not evolved along the same path, which is a little bit of what I was trying to get from Jason, is in moving a state with a long history of managed care, not even necessarily creating brand new programs or models, and they're having to really go through sort of tremendous waivers which are discretionary, you know, sort of processes where -- and provide an awful lot of, you know, sort of -- it's just a ton of work to justify potentially small changes that have been well-trod not only in their own state, but elsewhere.

And so, I think sort of just reflecting on the fact that these are -- you know, that so much still has to be waiverized, when really this has -- managed care has become a standard approach, and I'm really pointing out the need for evaluating whether -- you know, where are the pieces where CMS really needs to have real scrutiny on, maybe when a state is trying something brand new or different and we're not, that there's still a mismatch there in the evolution of the law versus the evolution of kind of the program and where we are.

CHAIR ROWLAND: Well, that would fit well with where we're going to expand the discussion of the waivers and the hoops one goes through now in that administrative chapter, but to also talk about how it could be more simplified. Richard.

COMMISSIONER CHAMBERS: I just want to follow up with Burt's comment about looking at

the dental carve-out and the ways of turning it upside down about the incentivizing. This experience I've had with my plan, you know, we have all 375,000 Medicaid beneficiaries enrolled in our plan in the county and we've discussed with the state probably three times in the last ten years is to carve dental services in. And the starting point is always less than fee-for-service, figuring there's some benefit there.

But even at just taking the fee-for-service dollars, I think the integration is an important component. If it's not about incentivizing above fee-for-service, it's incentivizing the coordination, integration of services with dental and other carve-outs. I'm a big proponent of carving in behavioral health also because there certainly are ways of increasing the benefits with the single entity being at risk and benefitting from the savings on acute care side for dental services.

So I just want to make sure we don't lose it. If we can't get states to at least push on the incentivizing above fee-for-services, to push for integration on the acute care side because I think single organizations can provide a better dental benefit overall than carve-out providers. Or at least holds the potential, put it that way.

CHAIR ROWLAND: Okay. Sara.

COMMISSIONER ROSENBAUM: I was just going to follow up on Andy's point, this question of whether the health system is evolving faster than the law is evolving and sort of where the tensions are. And I think in that vein, it might be important for us to think about how we actually point to the step that was taken in the Affordable Care Act to create accountable care organizations.

Now, they're very different creatures and their policy is still evolving, but Medicaid really has been the last bastion of a very old style, a very traditional health care system, and there, of course, is the Center for Medicare and Medicaid Innovation, which is going to do pilots and demos, including around organized

systems of care.

But the thing that's so remarkable about ACOs in this context is that it is mainstream Medicare policy now. It is mainstream Medicare policy, not a waiver policy, not a demo policy, to achieve a high level of integration in delivery.

And, you know, one of the issues in the ACO rules, obviously, is do you do retrospective or prospective enrollment, and remarkably, I thought, there was a lot of outpouring, when the rule came out, concerned about retrospective now having to do a lot with, of course, the mechanics of the ACO operation.

But the interesting thing was that you didn't hear an equal outpouring back the other way from people very concerned that Medicare beneficiaries would actually be prospectively, you know, with the right of opt-out, but prospectively assigned to their doctor and receiving care that way.

I think it's quite an astounding thing to have watched this enormous step happen in Medicare policy. It sort of crept up on us. And the question is, what are the implications of having taken such an enormous step in Medicare for bringing those kinds of tools to bear in Medicaid. We started down this path in 1997, obviously, in the Balanced Budget Act, but have, as Andy said, left many things defaulting still into a traditional fee-for-service program with an exception having to be drawn for organized systems of care in which people are members.

And the question is whether the ACO statute itself, in some ways, is sort of a subtle game changer that we ought to point to and say, you know, This is something that policymakers need to think about now. If we've crossed this line in Medicare, where does this leave us in Medicaid?

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I think that's interesting to point out, that in some ways it would be

going backwards in Medicaid in that Medicaid is already past -- in many ways, past the ACO model that is being ascribed for Medicare and into a managed care out of fee-for-service and the ACO would move it back into fee-for-service.

So I understand what you're saying, is that Medicare --

COMMISSIONER ROSENBAUM: It's not the model itself. It's the notion that people would be assigned to a delivery system that they are members of, and that they could elect to leave it, but they would be assigned to it. And they would be getting their care through an organized delivery system. This is quite radical for Medicare as a standard operation. That's all.

CHAIR ROWLAND: Richard.

COMMISSIONER CHAMBERS: But I'd also say is that the difference with Medicare is they've been unwilling to mandatorily enroll beneficiaries, so I agree with both of you. I think I'm not a proponent of ACOs at all, but see where I come from and you'd understand why, but it certainly is an unfettered fee-for-service environment, it's sort of managed care like and it's better than fee-for-service. And so, I agree as it certainly should be an option in places if there's going to be no managed care and it's a coordinated and integrated system of care that may be an option.

COMMISSIONER ROSENBAUM: And it's like an admission, you know. It's like an admission that we've crossed some rubicon and to the notion that you can sort of see over the horizon that the default in Medicare some day will not be, the people are just unorganized, then the default will be that you're organized, and the most sensitive, politically sensitive population.

So the question is, you know, what does -- what does the underlying message of that mean for the default in Medicaid still being that certain people are out.

CHAIR ROWLAND: Steve.

COMMISSIONER WALDREN: One thing I was -- struck me by Mike's comments when he talked about kind of that spectrum between fee-for-service and that kind of stuff and now we're talking about ACOs. I wonder about, and probably not for this report, but as we think about structuring our work moving forward with managed care or managing care, that maybe it would be good about talking about managing care and what are the tools available to the states and the Federal Government to manage that care.

And we could talk about capitation. We can talk about carve-ins, carve-outs. We could talk about the PCCM stuff. And then I think when we start talking about each of those tools, we could talk about what are the components to that. So Sara, you talked about other types of primary care case management, just more or less a bribe to say, Please stay in the network, and then Oklahoma is a little bit different.

That would give us an opportunity for each one of those tools to say, This is how we see it. When we talk about it, this is what we mean. So when we later on recommend certain things, we have kind of a stance to say, Well, when we say this, this is exactly what we mean, and make the framework. As we continue to evolve and new tools come out, we have a framework to kind of --

CHAIR ROWLAND: And some of the tools like when Patty mentions using her telephone hotline staffed by nurses or when Mike talked about using more nurses as care coordinators, what are some of the models out there as well. Other comments? Donna?

COMMISSIONER CHECKETT: I think just to emphasize the discussion we've had throughout the day on the importance of the dual eligible population. As a Commission our interest in questions about what are effective ways to manage the population, what examples do we have in states, how can the

role of Medicare special needs plans for dual eligibles contribute of the discussion, and although we touched, I think, in this report, we start down that road, we have a lot further road to go, and so just an observation that we want to make sure that people know we'll continue to look at that challenging and thorny issue, and also just as well that -- to emphasize that there are so many people who are going to managed care because they're interested in cost-savings and perceived cost-savings; yet, there's really very little known, especially very little current data on does managed care really save money, and that's another thorny question.

And so just acknowledging both of those issues and that those issues aren't answered in this first treatise on managed care. And I do want to compliment the staff. I think they've done a lot of work and the report looks good. I'm looking forward to seeing the final version.

CHAIR ROWLAND: If I could add just one comment, I think the other thing that the report does that's important is we keep talking about duals, but the report emphasizes the disability population, many of whom are not yet eligible for Medicare or may never be eligible for Medicare, yet have the same coordination of care issues except you leave the Medicare payer side out. And the role of managed care for that population is really one of the next steps that many states are taking, and so I think having that focus is also important.

And it's important to probably remind the policy community that every person with disability on Medicaid is not a dual, that in fact the disability population outnumbers the dual disability population on Medicaid.

Trish.

COMMISSIONER RILEY: That's actually where I was headed because I think I'm a little

jaundiced about what we can really do with duals unless and until we get Medicare at the table as an equal partner and can actually change the way financing works. And without the ability to do that, you can coordinate all you want, but you're not going to see any efficiencies or maybe effectiveness.

But I think we could even do a better job on the disability discussion. Don't refer to them as SSI but talk about persons with disabilities. Spend a little bit more time talking about who they are. It's DD kids. It's physically disabled. It's HIV. It's such a large group of people, and that's where states are paying totally themselves.

And while states come to managed care to look for cost savings, they do it because -- and maybe we need to say more about this -- the fee-for-service system has not done a very good job in how we cover persons with disabilities in that it's very costly with very little evidence about what we're really achieving, so that the managed care promise is quite real in that population.

So I would gin up that discussion. Talk more about the population. Talk more about fee-for-service a little bit more.

But I would agree. I think this paper does a real, makes a real contribution to the field particularly about talking about the complexity of what is managed care.

CHAIR ROWLAND: Because in fact many of them, when we look at MACStats, which we're going to come to next -- I mean many of the fee-for-service numbers that we look at reflect the disability population on Medicaid's use of hospital and other services because some of the dual costs are on the Medicare side of the ledger.

Other comments?

Well, I think that we're on a short timeframe, but I think we've got an amazingly great start at having

the material. We appreciate the draft that we got early, the draft that we got late and the conference call in the middle, and we look forward to seeing some concluding remarks that we can review. But certainly with all of the comments today, I think you have a lot of work to do this weekend, but I think it will turn out to be a great product.

And again, on behalf of all of the Commission members, we just want to thank the staff for the endless hours they put into making these reports and products so significant.

And especially thank you, Lois, because you've been sitting there for a long time today.

And I think we're going to turn now, speaking of statistics and data, to April Grady and our MACStats overview. Tab 7 of your book, but my book doesn't have it.

Okay. The stats, yeah, the stats are under Tab 3, but the overview session is at Tab 7.

But where do you want us, April? At 7 or 3?

MS. GRADY: You can just listen to me for now, and I'll tell you when to turn. How about that? So you can pay attention to me for now.

CHAIR ROWLAND: Thank you. Focus on April.

OVERVIEW OF MACSTATS

* MS. GRADY: And I'm not that kind of person if you know me.

In any case, as you know, you have a draft of the proposed MACStats for the June report in your binder, and the actual statistics are in Tab 3. Today, we know that you need some time to review these, but we want to get your initial feedback, and we look forward to some detailed comments once you have had a chance to look these over a little bit longer.

The proposed structure of the MACStats section in the June report comes in four pieces.

Basically, we're going to look at three substantive issues. The first two are trends in Medicaid enrollment and spending since the program's beginning up until 2008 or 2010, depending on when we have data available. We're also looking at current health characteristics, enrollment and benefits spending among Medicaid populations, including people with, persons with disabilities and long-term care users. The second sort of substantive issue that we're looking at is Medicaid managed care, and those tables and figures will supplement the chapter that you've talked about today.

The other piece that we propose for the MACStats is in front of these sections, these substantive sections. We'd like to include a guide that we're calling the MACStats Road Map, and the idea here is to provide a road map to guide readers as they examine the tables and figures that we present in MACStats. So that would apply in the June report and also future reports. This idea is to provide people with supplemental information that they can use to interpret what we're providing.

So you can make a note of the road map topics that are here on this slide, but what I'm going to do is walk through the tables and figures, some examples in each section, and give examples where there are particular technical or other issues that are addressed in the road map instead of going through these things in isolation.

So now you can pay attention to Tab 3. If you don't want to listen to me, you can look at some of the charts and figures that we have.

And if you want to flip to page 13, I'll let you get there for those of you who want to do so. This here is table in our first section which is Trends in "Medicaid Enrollment and Spending," and here what we're doing is looking at enrollment and spending growth over the program's history, beginning in 1966 and running through 2010.

What we are doing here in the road map in particular is pointing people to supplemental information about how to look at some of the trends that you see in these areas. So for example, if you want to look at 1996 and you look at enrollment, which is the dotted line, you'll see that enrollment actually declined starting in 1996. And that was one of the only times that's happened in the Medicaid program's history, and that was partially due to welfare reform and some of the eligibility-related changes that were happening.

So what we do in the road map is provide resources for people to look to, to interpret the numbers that we're showing here on the chart.

In addition, in this section, we also look at Medicaid spending overall. We look at the number of persons served by eligibility group. And we also look at components of growth in Medicaid benefit spending, looking at how much of the spending is attributable to growth in enrollment and how much is attributable to growth in spending per enrollee.

So again, I'm not going to walk through all of these individually but wanted to give you a flavor to familiarize you so that when you go through these later on you can have this in mind.

The second substantive section that we have in MACStats deals with current health care characteristics, enrollment and spending among Medicaid populations. So whereas in the first section we were focusing on trends, now we're looking at the current day, the current populations.

If you want to turn to page 22, we'll give you an example of the kind of detail that we're looking at. Now page 22 has a big scary table that's got a lot of interesting information in it, and you don't have to focus on all of that information. But what I want you to understand about this table and the two that follow is that our intent is to compare Medicaid and CHIP enrollees to people with other types of coverage, so that's the first point. And then the second point is to look at the Medicaid and CHIP population by

itself and then compare different subgroups of CHIP enrollees to look at their health characteristics, their demographics and that sort of thing.

So if you want to walk through an example on page 22, this table is looking at children under age 19. And if you look at the top row here and the very tiny numbers that are provided, what this is showing is that about 32 percent of all children are enrolled in Medicaid. That's sort of the middle of the left side of numbers here. And as you move over to the right side you can see that we limit the numbers to the Medicaid and CHIP population alone.

So following on the discussion that we just had about persons with disabilities, you can see here in this table that 3 percent of Medicaid children are receiving supplemental security benefits, or SSI benefits. And going to Trish's point, these are children who would generally be categorized as officially disabled in Medicaid program statistics.

But if you focus on the column to the right of the SSI column, these are kids who are not SSI, but they are CSHCN. So this is one of Lu's favorite acronyms. This is Children with Special Health Care Needs. And this is defined using a number of measures from a survey, but things like does the child have one of our chronic conditions, have they been on medication for a chronic condition for the past year. There's a whole host of things that categorize you as a Child with Special Health Care Needs.

And using that definition, almost a third of Medicaid children are defined as having special health care needs but would not necessarily show up as disabled in most of the program statistics that are presented on the Medicaid program.

CHAIR ROWLAND: April, you used this off of the National Health Interview Survey. Could you

MS. GRADY: That's correct.

CHAIR ROWLAND: Could you explain to the group why you're using this instead of the census data which everyone is more familiar with and what some of the differences would be in the numbers so that if someone sees a number here that's different from one they've seen published before they understand why.

MS. GRADY: Right. So there are two things. The census data that you're referring to are generally used when we're looking at health insurance coverage estimates, so what kind of health insurance do you have. And that's generally where the detail stops with the census figures. There might be a couple of health questions, but nothing in any great level of detail.

With the National Health Interview Survey, the NHIS, which is the source for these Tables 3 through 5, they are surveys that are very specific to health and health-related measures. So in addition to asking about your health insurance status, they also ask about your general health, any conditions that you've been diagnosed with, how frequently you visit a doctor or an emergency room. There's a whole host of information that's available in this survey that are not available in other places.

So as with all surveys the design of the survey can make a difference in the estimates you get, and that's why there might be some slight differences from what people are used to seeing. In general, the surveys are pretty close to each other.

So the NHIS is considered to be one of the most reliable sources of estimates on health insurance coverage in particular because it's so specific to health. People are thinking about the issue, and the recall of their health insurance status may be better. And again, it's the only place for some of those health status and other variables. So that's the reason we're using it.

One of the shortcomings of the survey is that we can't get state-level estimates, unfortunately. So that's why the tables that we have here are national.

VICE CHAIR SUNDWALL: Could I ask a question on this column?

MS. GRADY: Sure.

VICE CHAIR SUNDWALL: What I finally figured out is it's the insurance coverage, not the rate of growth. It's the percent insured.

MS. GRADY: Yes.

VICE CHAIR SUNDWALL: What puzzles me a bit in the first category, All Sources of Insurance, you've got Private, about a third; Medicaid/CHIP, 44 percent. What is Other? The other is a lot, 41 percent. If it's not commercial or Medicaid, what's Other?

MS. GRADY: I'm looking to Chris Peterson here, but I believe it might be military coverage through a parent who's in military, and maybe -- I'm not sure what else is involved there, but we can get back to you on that.

VICE CHAIR SUNDWALL: I think it's a mistake because it doesn't add up. But anyway, check that. It seems high for a category of Other.

MS. GRADY: There's a footnote, yes. So I can look.

UNIDENTIFIED SPEAKER: It may be Tricare.

MS. GRADY: Yes, so it's mostly military coverage.

UNIDENTIFIED SPEAKER: That doesn't add up.

VICE CHAIR SUNDWALL: No, it doesn't.

UNIDENTIFIED SPEAKER: Which one?

VICE CHAIR SUNDWALL: It's here, this column, Other under All Sources of Insurance.

MS. GRADY: Chris is coming to intervene.

VICE CHAIR SUNDWALL: It's very high.

MR. PETERSON: The top row is 2.7 percent.

VICE CHAIR SUNDWALL: Well, that makes more sense.

MR. PETERSON: That makes more sense, right. So April was probably about to walk you through that. But everything below that, you look at it so that it adds to 100 percent.

So in other words, if you look at Medicaid/CHIP, we'll just walk down; 32 percent are in Medicaid and CHIP. Then you can break those kids up by age.

VICE CHAIR SUNDWALL: Okay.

MR. PETERSON: And this, if you look at the age group, that all adds to 100 percent --

VICE CHAIR SUNDWALL: I got you.

MR. PETERSON: -- because we're trying to say okay, among these kids who are Medicaid and CHIP how are they broken up by age? And so that's where the numbers start to look at little different.

So it might be helpful if we kind of separate this top row with a little bit to make very clear. Like okay, this is just a top line letting you know how many kids are in these various sources of coverage, and then below that now we're trying to --

VICE CHAIR SUNDWALL: Sure. So all the age groups will total the 2.7. I mean to get there, that's 2.7.

CHAIR ROWLAND: So 2.7 percent of all children are in the Other category.

VICE CHAIR SUNDWALL: Yes.

CHAIR ROWLAND: And of that small amount of children, 41 percent are 0 to 6, 23 percent are 7 to 11. So it's the distributions within these tiny groups over here.

VICE CHAIR SUNDWALL: The vertical column, yes. Thanks.

COMMISSIONER GABOW: So it's probably in your road map, how to read the tables.

[Laughter.]

MS. GRADY: Lu is shaking her head yes.

COMMISSIONER GABOW: When you add across, when do you add down.

MS. GRADY: That's exactly right.

COMMISSIONER GABOW: You can't possibly tell that.

MS. GRADY: That's exactly right.

MR. PETERSON: That's why we need road maps.

MS. GRADY: And you know, thank you for humoring us because I know this is a difficult thing to pick up, right, without having seen it before the meeting.

CHAIR ROWLAND: But when we get down to the bottom, to the specific health conditions, those are not the only health conditions. So there you can have children with -- those don't add up to 100.

MS. GRADY: Well you could have multiple conditions.

CHAIR ROWLAND: You can have multiple.

MS. GRADY: So they will not sum to 100 percent.

CHAIR ROWLAND: So that's another thing you have to clarify in the tale, where it's summing to 100 and where it's not.

COMMISSIONER RILEY: This has always intrigued me, this data on first blush. Self-reported

health status has always struck me that it may be that low income people with less education may report their health status differently than higher education, and it's interesting to look that again here we see significant differences in reported health status. But when you look at the specific health status and health conditions, there's variation by ADHD and asthma and a couple of them. Most of them look the same.

So I'd love to know what's statistically significant here. I'd just like to know do people's perception of their own health get realized when we know although these are self-reported health conditions as well.

COMMISSIONER ROSENBAUM: The second one is who have been told.

COMMISSIONER RILEY: Told, okay.

COMMISSIONER ROSENBAUM: [off microphone.]

I think this table is unbelievably valuable, and it just needs a fair amount of text, and it needs a couple of different kinds of text. One is to explain exactly what you're reading.

The other thing that I think really needs clarification -- there are a couple of things on the Children with Special Health Care Needs. One is, of course, just reinforcing maybe with one or two examples what would differentiate a child who has enough of a disability to get SSI from a child who is a Child with Special Health Care Needs, so to understand that.

And the other thing always to remind people about is yes, I mean the burden of illness is much greater for low income children. But what is so startling here, which is the thing that's easy to forget, is because Medicaid does not have a preexisting condition exclusion the program picks up children, especially children -- even though it's open to all poor children, there is, because of enrollment issues and everything else, a historic tendency to pick children up at the point of service, just like with adults, but we see it very clearly here.

And so we really don't want people to think that 30 percent of all low income children are children with special needs because that has consequences itself. But what is important to understand is that Medicaid is designed to be able to pick a child up either when the child is low income or when the child has heightened health care needs, and so you see these high numbers.

CHAIR ROWLAND: I have a suggestion. I think that long tables are hard to read and that maybe this table is best broken up into three tables -- one that looks at sources of insurance coverage and does everything up to the general health stuff, one that looks at the health and one that then looks at utilization -- keeping the same columns, but then you can offer more of an explanation of what's in each of those three. And it will get bigger numbers, so some of us can read them better.

VICE CHAIR SUNDWALL: I really do like the side-by-side though with all insurance, and the CHIP and Medicaid. That is very useful.

And one interesting point is if you look at General Health Assessment the total of Excellent and Good between the two groups is about the same.

UNIDENTIFIED SPEAKER: [off microphone.]

VICE CHAIR SUNDWALL: Yes, one is good, but I mean I'm just pleased that –

CHAIR ROWLAND: Remember but Total Health Assessment though asks you to compare yourself to people like you, to your peers.

VICE CHAIR SUNDWALL: Oh.

CHAIR ROWLAND: So it often is not a measure of how you think you're faring against someone who has a million dollars.

COMMISSIONER RILEY: But isn't it misleading because I think when you look at all children

versus all Medicaid and CHIP children, because a disproportionate number of children are in Medicaid and CHIP, it's really the private versus the Medicaid and CHIP that we should be looking at?

CHAIR ROWLAND: Right.

COMMISSIONER RILEY: It seems to me.

MS. GRADY: I just want to point out one thing. Trish, you had asked about statistical significance, and the little double bars start to indicate when the subgroup of interest is different from Medicaid as a whole. So for example, you can see in the SSI column in many cases the SSI children are significantly different than the child Medicaid population as a whole.

COMMISSIONER RILEY: I was interested in the private versus the Medicaid because we always report significantly different health status, and as you look through this, that's significant.

MS. GRADY: And the same applies there. So if you see stars next to private, it means it's significantly different than Medicaid.

COMMISSIONER RILEY: Okay. Great.

CHAIR ROWLAND: Yes, Norma.

COMMISSIONER MARTINEZ ROGERS: I'm really kind of surprised at the percentage of the Hispanics that are uninsured because we're the highest uninsured population in the United States in comparison to the white non-Hispanic.

Of course, there might be more white non-Hispanic kids than there are Hispanic; that's probably it. I just answered my own question.

MS. GRADY: We'll definitely take a look at that, but you're right, that generally Hispanics have a very high rate of uninsurance.

COMMISSIONER EDELSTEIN: And April, NHIS does ask parents about being told that their kids have cavities.

MS. GRADY: Okay.

CHAIR ROWLAND: The other thing that isn't here is you didn't do anything around immigration status.

MS. GRADY: I will defer to Chris. Do we have that in the NHIS?

CHAIR ROWLAND: You can sometimes just citizen, non-citizen.

MS. GRADY: Well, we can look into that.

CHAIR ROWLAND: Because obviously that plays in very largely to some of the issues about some of the uninsured Hispanic children are not actually eligible.

COMMISSIONER HENNING: Well, the other thing is if you look at Hispanic are 21.4 percent of the population of all children and yet 38.6 percent of the uninsured, it kind of takes care of that question.

COMMISSIONER MARTINEZ ROGERS: [off microphone.]

COMMISSIONER HENNING: Yeah.

COMMISSIONER MARTINEZ ROGERS: [off microphone.]

COMMISSIONER HENNING: Yeah.

MS. GRADY: Actually, let me just clarify. Again, this is where we're going to have to put these totals in there. So the way this reads is that, correct, 21.4 percent of all children are Hispanic; however, 38.6 percent of Hispanic children are uninsured.

So we will clarify where things sum to 100 percent to help the interpretation of this table. That's a great point.

COMMISSIONER MARTINEZ ROGERS: Does the cross mean that no one ever told the parent that the child has a disease? Is that what that means? What does the little cross mean?

MS. GRADY: The cross I believe were cases where we had so few children in the survey sample that we couldn't produce an estimate, that the statistics aren't valid.

COMMISSIONER MARTINEZ ROGERS: Well, it amazes me about diabetes

MS. GRADY: Yeah, that might have -- it's partially an artifact of the survey itself, not the way that people respond to the survey.

COMMISSIONER MARTINEZ ROGERS: Okay. I got it.

MS. GRADY: Okay. Okay, so we have three sets of these tables -- I'm not going to go through them -- for different age groups.

CHAIR ROWLAND: Why? We could comment on every one of them.

[Laughter.]

MS. GRADY: You could, and I look forward to your written comments.

COMMISSIONER RILEY: But the adult chart -- I have to say every time people try to sort of talk about Medicaid and make it like private insurance, the adult one is stunning. It just shows how different the populations are. It's great.

MS. GRADY: Okay. Also, so we have these three tables that are based on NHIS data, and the remainder of the tables in this section are based on administrative data on program enrollment and spending that you've heard all about from me in the past.

I want to point out that here's where we face the issue of children who, or enrollees who are categorized as disabled. The Medicaid program has a particular way of categorizing folks as disabled, and it

is generally tied to your receipt of supplemental security income benefits. There are exceptions, but for the most part if you're categorized as disabled in Medicaid you're probably receiving SSI or you're in a very similar situation. But in any case, you've had an official disability determination done. In most cases, it's been determined that you cannot work significant hours and therefore are entitled to cash assistance for that reason.

So we're not picking up in the rest of these tables Children with Special Health Care Needs who don't receive SSI. They would be categorized in the general child population. So we sort of lose that level of detail, but again, it's what we have in the official statistics.

VICE CHAIR SUNDWALL: Is that Table 4?

MS. GRADY: Sorry.

VICE CHAIR SUNDWALL: Is that Table 4?

MS. GRADY: I'm speaking generally about the remainder of the tables in this section.

VICE CHAIR SUNDWALL: Oh, okay.

COMMISSIONER ROSENBAUM: But I do have one question. On Table 4 for adults, you ask under Disability and Work Status, receives SSI for disability. Not Social Security generally, just SSI?

MS. GRADY: If you are under 65 and you're receiving SSI, it's because of a disability.

COMMISSIONER ROSENBAUM: No, no. But I'm asking Social Security disability insurance also, SSDI.

MS. GRADY: We are going to have SSDI in here. It's just missing from this particular table.

COMMISSIONER ROSENBAUM: Okay.

CHAIR ROWLAND: April, in Table 5, you have characteristics of non-institutionalized

individuals age 65 and older, and you have your category, All Medicaid/CHIP Aged Adults. I really wonder how many CHIP people are over 65, and I would hate to have a table like this used for people to think that CHIP was being used for that population when it's not.

MS. GRADY: I think we're fairly safe to remove the CHIP label. The reason we have this in the other tables is because the surveys are not good at differentiating between whether you have Medicaid or CHIP coverage. But you're right; this population really --

CHAIR ROWLAND: You know, you can drop a footnote and say there's no way. But I would hate to have someone misread the table and say CHIP is covering all these people who should be getting Medicare.

MS. GRADY: You're right.

COMMISSIONER EDELSTEIN: Not to steal Denise's thunder, but it might be useful to put pregnancy back in the pediatric group because we have the adolescents in there.

MS. GRADY: Actually, I don't believe that pregnancy is asked of adolescents, but we can double-check.

[Laughter.]

MS. GRADY: We will check on that though.

Okay. I'm not going to walk you through the rest of those tables that I talked about. I'm going to provide you with one example that I think may be of interest because I think it's something that's come up in prior meetings.

It's on page 39, so I'll let you get there. And unfortunately, page 39 doesn't have a number on it, but page 40 does. So if you turn back 1, it's Figure 7, and this is Medicaid benefit spending per enrollee

based on long-term care use.

What I want to point out here is have you focus on the last three bars in this chart, the tall ones, and these are enrollees who require an institutional level of care. So those are people who may be served under a home and community-based services waiver. One of the requirements is that you require an institutional level of care. Or, they may be people in institutions like a nursing home.

And what you can see here is that the costs per enrollee for these folks average between $40,000 and $60,000 per year. So they're significantly different than other enrollees, but they still have a substantial amount of acute care spending. There's a lot of hospitalizations that go on and other non-long-term care spending that they may be using.

So just to put the 32, or the 40 to 60 in context, among folks who use no long-term care, their per-enrollee spending is less than $4,000 per year. So there's really wide variation in the Medicaid populations that we're talking about.

And we have several other tables and figures that demonstrate both this variation across groups and also tables that demonstrate the variation across states because that's also very large.

CHAIR ROWLAND: Denise, did you have a question?

COMMISSIONER HENNING: Yes, just real quick. Where do the people that are in like assisted living facilities, where do they fall?

MS. GRADY: If Medicaid is paying for care in that assisted living facility, then they're going to show up in one of the long-term care groups on this chart, but it's unclear. It depends on how that facility would be categorized for purposes of a Medicare payment.

CHAIR ROWLAND: Most would not be. Most would not be.

COMMISSIONER ROSENBAUM: If you are low income, you would be in a custodial care arrangement. It would be the equivalent of assisted living. It would be paid for out of your SSI check.

If you are middle income or whatever and you're in an assisted living facility, unless the state has a special waiver, there's no room and board payment for that. So you would be getting your medical care, ambulatory care, but room and board would not be reflected.

CHAIR ROWLAND: In this chart, what's being considered institutional is when Medicaid has made an institutional payment.

MS. GRADY: And that's either to a nursing facility or an intermediate care facility.

CHAIR ROWLAND: Yes, but not to an assisted living facility in most cases unless there's a special waiver.

MS. GRADY: Yes.

VICE CHAIR SUNDWALL: The last column, could you explain that? It's the highest chart, but it's using both. I guess home and community-based services, and institutional care. Are people going in and out?

MS. GRADY: That's our guess. We have aggregate data for the entire year, and we can't parse out the timing or the order of this spending. We just know that you have this spending during the year.

So my speculation, based on what we see here, is that these people have very high hospitals costs. So they may be people who started out in the community, who had an event that required a hospitalization and then were transferred to an institution, but again that's just speculation.

We have other data sources that we can delve deeper into in the future, but this one in particular doesn't quite get us there.

VICE CHAIR SUNDWALL: Okay.

MS. GRADY: Okay. So that wraps up Section 2, and the final section that we have is on Medicaid managed care which you've heard a lot about today.

So I want to focus just on one table here because I think this is something that is raised throughout the chapter and we come back to again and again. On page 40, which is Table 9, here we show total Medicaid managed care enrollment by state, and then we show the percentage of enrollees who are consider to be in managed care, using different definitions, ranging from the broadest definition to the most narrow.

So if we look at any form of managed care, which would include HMO-type coverage where the benefits are broad, under a risk-based contract, if we include limited benefit plans and we include primary care case management, more than 70 percent of Medicaid enrollees are in managed care.

But if you start to narrow that definition and you only count people who are in HMO-type plans with a broad set of benefits and people who are in a primary care case management program of the type that Oklahoma described today, then only 61 percent are in managed care.

And then if you further limit your definition to just people who are in those HMO-type coverages, it's less than half.

So throughout the chapter, I think Lois and folks have been careful to describe the kind of managed care they're referring to at any given point in time, but this table is a good reminder of the fact that you need to know what you're talking about when you're talking about managed care, what type of coverage.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: This goes back to an earlier discussion we had today, and it's this issue of what do we call comprehensive managed care entities. In the law actually, they're called

entities that contract for three or more coverage services. They are not often full risk. They accept risk, but you can accept risk and be a smaller entity.

And of course, even again, even PCCM arrangements may have upside risks. They may have shared savings.

And I think it would be a good idea. I realize how hard it is to change terminology, but I think it's a mistake to lead people to believe that because you're doing business with comprehensive entities they are at "full risk" when they're not at full risk and that smaller entities may not be carrying risk.

So my recommendation would be that we call them comprehensive arrangements versus more limited managed care arrangements. I mean I don't know what the terminology is, but I'm worried about Congress thinking, or anybody thinking, that somehow you can contract with these entities and they are bearing all the risk and the government bears now risk. That is not true.

So I just throw that out there.

MS. GRADY: And I should have pointed out that because these tables are draft we haven't yet conformed to the terminology that's used in the managed care chapter. And correct me if I'm wrong, but I believe those comprehensive or broad-based plans are being referred to as risk-based right now, not full risk. So that's the current state of affairs on that.

CHAIR ROWLAND: Okay. Other comments?

Donna.

COMMISSIONER CHECKETT: I'm sorry. Are we ready to move on to the next table?

I'm sorry. I'm so bad. My entire like school career I was always ahead. You know. I'm sorry.

CHAIR ROWLAND: We're on the next table.

COMMISSIONER CHECKETT: All right. Thank you. Because on Table 10 --

UNIDENTIFIED SPEAKER: There's medication out there.

[Laughter.]

COMMISSIONER CHECKETT: Thank you very much for that.

On Table 10, my concern about Table 10, first of all -- and I know, April, that you'll get that we're not calling them commercial versus Medicaid MCOs because --

MS. GRADY: I will call them whatever the managed care chapter folks want.

COMMISSIONER CHECKETT: -- commercial MCOs can't be a Medicaid MCO.

But I'm really concerned about this table because just scanning the states that I'm familiar with I see things that are just simply wrong. And if it is CMS data, maybe there's nothing we can do about that, but it's alarming. For instance, I would just point out -- tell me. Maybe I'm reading this wrong.

But like all right, Missouri which I know very well, 45 percent full risk, that would be accurate. But to say that there are -- none of those plans are "commercial," and we know what that means, MCOs is simply wrong.

And going through and looking at Ohio, that would simply be inaccurate. Washington is inaccurate. And I mean it's not like mildly inaccurate; it's wrong.

So I don't know what to say at this point.

MS. GRADY: Yes. So the issue we have here is this is the way that states report the data to CMS, and the states are provided with a definition of commercial when they're asked to report this data, and then they decide how to categorize their plans. And it may be in this case that Missouri didn't feel that their plan met that definition.

COMMISSIONER CHECKETT: [off microphone.]

[Laughter.]

UNIDENTIFIED SPEAKER: Who wants to go back -- [off microphone].

COMMISSIONER CHECKETT: But, no. But you know the problem is that there's a number of states here that just based on my knowledge of those plans -- I mean Arizona is wrong. I could just go down the list.

I'm just concerned about it. And if anything, if all we can do is just emphasize that, that it's the self-report by the states.

COMMISSIONER ROSENBAUM: That it's self-report data.

COMMISSIONER CHECKETT: But it's really inaccurate.

COMMISSIONER RILEY: You also get confusion because on Table 6 you've got total enrollment, but it's from 2008, and then on Table 9 you've got total enrollment that's 9. I'm not sure they look right to me, but --

MS. GRADY: I'm glad you raised that point because that's one of our road map issues. We have a guide to interpreting managed care enrollment and spending because, again, different data sources at different points in time.

One thing I'll point out about Table 10 and most of the tables in this back section, they include Medicaid expansion CHIP enrollees. That's just the way the data are reported. In our March MACStats, we were very careful to pull out regular or traditional Medicaid enrollees from Medicaid expansion CHIP enrollees, and we don't have that option here.

So one of the things in the road map we discuss is sort of what are you looking at when you look at

these tables, and what we're going to do is be very clear in the source, or in the notes for the table that folks should refer back to that discussion to understand what they're looking at here.

CHAIR ROWLAND: But if we think a table is wrong, should we be printing it?

COMMISSIONER CHAMBERS: Yes, it's really off because --

EXECUTIVE DIRECTOR ZAWISTOWICH: It is the source data. It is the source data from CMS, and if we feel strongly about it we don't have to publish it. We were just really trying to figure out what was the enrollment by state, what was the experience at the state level, and these are the best data that I think we have.

CHAIR ROWLAND: If we publish it, I think it needs more than just a mention in a roadmap. I think it needs a big caveat at the bottom of the table that these data are being reported according to what the states have reported to CMS and are not -- you know, because this looks like we've analyzed. It says "Analysis of CMS Medicaid Managed Care," which then sounds like we are analyzing and verifying these data. And if we don't think they're correct, I don't think we want that as our --

COMMISSIONER RILEY: But is this an example of the CMS over-counting or duplicate counting?

EXECUTIVE DIRECTOR ZAWISTOWICH: It's not really that. It's not an example of that. It's the nature of the data being self-reported from the state to CMS, and that's really what it's illustrating. The over-counting is another issue.

VICE CHAIR SUNDWALL: So Donna, so I understand it, you say it's incorrect because you're aware that in some of these states they have full-risk commercial plans?

COMMISSIONER CHECKETT: Yes. Like for instance, in Arizona it's saying that 90 percent,

that there is Medicaid-only MCO penetration. Well, for instance, we know United Healthcare, which is not, I would not say is a Medicaid-only by virtue of this really bad definition of Medicaid-only. They do business in Arizona. So I can tell you, looking at that one then, that table is incorrect.

Missouri. I could name a "commercial" plan doing business there. Coventry has got probably 50 percent of the market there. That one is wrong.

I don't know. I just go through them.

VICE CHAIR SUNDWALL: But full risk.

COMMISSIONER CHECKETT: By looking at Ohio, that's wrong just because it was doing business there. I just know these things.

Washington is wrong.

COMMISSIONER CHAMBERS: And to tell you, like I was going to say in California, I think it's where they're mixing it up is they say commercial MCO is if you're a plan that provides a product that is commercial because like there you have 9 percent.

Like for instance, we must -- I mean we must be in the commercial MCO because we provide CHIP which the state classifies as a commercial plan in Medicare. It's not Medicaid. So they're throwing us in as a commercial MCO.

It's just totally -- I mean the numbers are totally wrong.

VICE CHAIR SUNDWALL: The variation is extraordinary because Utah is correct. We have zero risk-based managed care, but if you look at another part of the report we have 86 percent in some kind of managed care, whether it be the primary care.

CHAIR ROWLAND: April, are any of the numbers in this table things we've also cited at the

national level in the overall report?

MS. GRADY: I'm looking to Lois and Jen because I'm not sure. I think -- is there any discussion of the commercial numbers in there?

MS. SIMON: Just a little bit. A very, very -- [off microphone].

COMMISSIONER CHAMBERS: My question would just be what's the point of us trying to say commercial?

CHAIR ROWLAND: What's the point of putting this in?

COMMISSIONER CHAMBERS: I mean I'm trying to figure out what are the differences. There are plans that are full risk. Is it -- I don't know.

COMMISSIONER ROSENBAUM: I think the crucial dividing point that they're trying to get at, the terminology is so messed up, but there are two kinds of sponsors in the world. There are private sponsors, and there are public sponsors in the group market. And I think what they're trying to say is are you a company that sells products in both the privately sponsored group market and the publically sponsored group market, in which you're like Aetna.

COMMISSIONER CHECKETT: A multi-product company.

COMMISSIONER ROSENBAUM: Yes. Versus a company like say the Neighborhood Health Plan of Rhode Island that really is only in a publically sponsored market. It could be Medicaid. It could be CHIP. It could be a combination of the two.

The uphill battle we've got here is how do we get out from under so many years of terminology that is wrong. And one question is whether we address somehow, even in the managed care report, the fact that one of the things that makes studying Medicaid managed care challenging is because the terminology

that's grown up around is unclear, and so the evidence is unclear. You know.

VICE CHAIR SUNDWALL: Should we use this table to illustrate that problem, or should we not include the table?

COMMISSIONER CHECKETT: Give me a red pen.

[Laughter.]

COMMISSIONER CHECKETT: And I'll [off microphone].

CHAIR ROWLAND: We'll put the table in as edited by Donna Checkett.

Judy.

COMMISSIONER MOORE: It does seem like we should flag this in some major way, not just let it go this way or not put it in at all. I'm not sure where to do that, whether in the chapter or in the --

CHAIR ROWLAND: I presume if we don't include it that someone else can go to another data source and get the same set of numbers from CMS, or not?

MS. GRADY: Yes. This is available on their web site.

CHAIR ROWLAND: So if we do include it, I don't want it said that it has been analyzed by us. It should be cited to the CMS web site and with maybe a big box at the bottom that explains there are definitional issues here and this is being included only because we're trying to be as comprehensive in the data that you might see elsewhere but that we have serious differences in the way the definitions are being used.

MS. SIMON: In the report, we do say that, but very, very -- just one sentence. We basically talk about the distinctions.

CHAIR ROWLAND: Because it's probably important if it's mentioned at all in the report -- and

we do have some of these terms that are in the report -- that someone not be able to say well, we went to the CMS web site and we got this table; why didn't MACPAC consider this table? I think we should explain why we didn't consider it.

COMMISSIONER MARTINEZ ROGERS: I think that you should also include a statement in there stating how they get this information, that it's self-reporting from the states.

MS. GRADY: And I was going to say if people think it's useful what we can do is actually quote from the instructions that states are given, the definition of commercial that they're provided to report this information, just so people have that as a reference.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: But I would like to get the balance from the states to make sure because often the reasons -- you know. We slap states for not reporting, and we should when they're not reporting things that are useful and needed. But when data is not used and it's just another report, then I don't want to slap states in our MACStats thing. So I want to get a sense of what the states think.

And I'm wondering if we shouldn't have -- it doesn't quite fit with MACStats, but I wonder if we ought to have a separate section at the back about sort of data issues, data needs, and include it there and say: We are taking on as MACPAC a review of data, a clarification of data. We're digging deeper. There are issues with the data that include, and those are in evidence in these charts about which we have questions.

CHAIR ROWLAND: It certainly could be in our concluding chapter.

COMMISSIONER RILEY: But if it's in MACStats, somebody will pick it up and say according to MACPAC.

CHAIR ROWLAND: Well, that's why I think we need a box.

COMMISSIONER CHAMBERS: Could I just make --

CHAIR ROWLAND: A bold box.

COMMISSIONER CHAMBERS: I probably didn't say it very eloquently before, but I'm just getting to the basic premises. It doesn't really matter anymore.

I mean it's like if it's all about sort of the Robin Standard. It's that you want quality access and cost effectiveness. Don't you want everybody? It doesn't matter whether -- is commercial bad in Medicaid-only plans or good? I mean it's just sort of maybe at one time it was --

COMMISSIONER COHEN: I have the exact same question. Do we have one finding in the report, even a single one, where it turns on whether a plan is commercial?

And we don't even need to be saying that sponsorship doesn't matter, but I think if today we were going to do analysis we wouldn't pick this dimension on which to. In today's world, people talk about sometimes provider sponsorship, safety net sponsorship, nonprofit sponsorship, but like commercial versus Medicaid-only I just don't know if that's that relevant today.

And if we don't have any findings --

COMMISSIONER ROSENBAUM: Well, we do have a whole section in the report that describes plans by ownership.

COMMISSIONER COHEN: But I'm saying are there any findings about quality access or anything else where there's a study that says this kind of a plan is like this and others are different?

COMMISSIONER GABOW: Well, we don't have a study, but if we get back to the safety net issue which is generally Medicaid-only plans usually, or Medicaid/CHIP, not always, but how they have a

unique relationship with the safety net or enable it to have a funding stream. So I think we do point that out, not by ownership so much as -- well, it is by ownership I guess.

I think what this table points out -- and I don't think we can separate out one table from everything else -- is that definitions matter in this very complex area and that this is a great example where the definitions are confusing and make it hard to analyze it.

CHAIR ROWLAND: And we can perhaps raise the fact that this is a distinction that's no longer effective and should there be a redesign of how the data is being collected by CMS to better reflect the evolution.

COMMISSIONER RILEY: Could the box also refer back to the report where we -- because I think we have done a real service to talk about the real definitions. These are arbitrary definitions that we're not using. It takes us back.

CHAIR ROWLAND: I'm talking -- yes. I think that we also can use some language about this in our concluding chapter.

COMMISSIONER RILEY: Right, right.

CHAIR ROWLAND: The one where we can then refer back to our report.

I don't know how much you can do in the stats section, but I do think that it just is not useful to not put this in with a lot of caveats. But it might be useful to have it in there just as an example of how [inaudible] it can be.

UNIDENTIFIED SPEAKER: [Off microphone.]

CHAIR ROWLAND: Do not use, right. Bad table.

MS. GRADY: And that's why I said we do have one section in the report that does compare

Medicaid-dominant from commercial. And there are a bunch of studies, but they're all really old. They're from like 2001. So they're pretty much outdated.

CHAIR ROWLAND: Well, maybe that goes with saying studies are old. The distinctions are blurred. Time to move on.

COMMISSIONER CHAMBERS: Yes, that's the point because it's sort of like the race question. Remember 30 years ago, it was White, Black, Other. And today, it's like there are so many categories.

And I think it's the same way with plans. Because you're a Medicaid-focused plan that provides private insurance to small businesses, what are you then? I mean it's a commercial product. So you'd have 50 different variations on it.

So we're beating a dead horse, but just to --

UNIDENTIFIED SPEAKER: But we're good at it.

[Laughter.]

CHAIR ROWLAND: You want to do Table 11, April, or are you ready to call it a day?

MS. GRADY: I'm sure that Donna has some comments on Table 11, so we can move to that one.

But I will say about Table 10 we can keep it in. We'll put some big caveats in, and then we'll also refer to appropriate places in the report for people who want more information.

CHAIR ROWLAND: And the caveat should be like a big box as opposed to just a note.

EXECUTIVE DIRECTOR ZAWISTOWICH: With a skull and crossbones.

[Laughter.]

CHAIR ROWLAND: Sure. Data danger. MACStats and Data Danger.

MS. GRADY: I was worried that MACStats would be boring, but you guys have really --

[Laughter.]

UNIDENTIFIED SPEAKER: This has been riveting.

COMMISSIONER GABOW: Remember this is a group that loves data.

MS. GRADY: That's true.

MS. GRADY: So we have two remaining tables, and if there are any comments on those I'm happy to go through them.

VICE CHAIR SUNDWALL: Donna?

CHAIR ROWLAND: Aetna right at the top.

COMMISSIONER CHECKETT: [off microphone.]

[Laughter.]

COMMISSIONER CHECKETT: Actually, I'm serious. I can tell you some other things like -- I will stop here, but like AmeriChoice is actually owned by United Healthcare, so you should roll those two together. You should roll UniCare by WellPoint and WellPoint together. Some other issues. Some plans missing. But I will pause.

VICE CHAIR SUNDWALL: This is 2009.

COMMISSIONER CHECKETT: Still wrong.

MS. GRADY: We'd love to get that feedback.

COMMISSIONER CHECKETT: But not as bad as Table 10.

VICE CHAIR SUNDWALL: Was it wrong in 2009?

COMMISSIONER CHECKETT: Yes. It's just -- [off microphone.]

MS. GRADY: But any other resources you have would be great.

CHAIR ROWLAND: Okay.

MS. GRADY: Okay. Well, I think that concludes the discussion of MACStats. Thank you for making this fun,.

CHAIR ROWLAND: Trish has a comment.

COMMISSIONER RILEY: I'm still sort of intrigued with the issue of -- I've always been intrigued with the issue of disability. And when we go aged, blind, disabled, it's an understatement.

And when you look at that earlier chart, I think it showed 3 percent of children are in SSI and 30 percent are not, but they're children with special health needs. So we've got to do a better job getting a better definition of disabled and looking at particularly at -- you know. Nobody has looked at DDMI kids, and it's a huge cost driver. It seems to me --

UNIDENTIFIED SPEAKER: What about the ADA definition -- [off microphone.]

COMMISSIONER RILEY: And we've got to find a way for the data because when we talk about disabled children and we're talking about 3 percent versus 33 percent, we are making conclusions that are inaccurate and incorrect. So I think we have a huge responsibility to try to figure this one out and be able to show the data differently someday.

CHAIR ROWLAND: We'll add it to our Data Danger list.

COMMISSIONER RILEY: Exactly.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I just want to say I love the MACStats.

CHAIR ROWLAND: Okay.

UNIDENTIFIED SPEAKER: Thank you.

CHAIR ROWLAND: Thank you, April. See, you thought you'd be five minutes. Show us a table and we can talk about it for an hour.

PUBLIC COMMENT

* CHAIR ROWLAND: I'd like to now turn to any of the members of our public who would like to talk about data dangers of MACPAC next steps to please join us at the mic and identify yourself.

MS. MORESCA: Hi. My name is Andrea Moresca. I'm the Director for Federal Policy and Strategy for NAMD, which is the National Association of Medicaid Directors. As some of you know, it's a relatively new organization, and some of you may not know of it, but we are a new group. We are the only group representing the Medicaid Directors in the 50 States, the District, and the Territories.

We appreciate the discussions and the very good work, the report, the March report, which has a lot of very valuable information, so the work of the Commissioners and the staff is very much appreciated. NAMD does have some concerns, however, about how the chapters of the March 2011 report were used, and specifically as the basis for the Centers for Medicaid, CHIP, and Survey and Certification Proposed Regulation, which addresses methods for assuring access to covered Medicaid services.

While States have concerns and questions about the regulation and the framework, the point that I want to convey today on behalf of our members is that -- relates directly to the way in which the report and content was utilized and interpreted. We noted in the report summary that it was intended to be a foundational report and to lay the groundwork for the recommendations in future reports. We're concerned that CMCS misinterpreted the Commission's initial framework as a specific recommendation. As you know, the agency has proposed to use this framework to define access standards and establish a mandatory process for measuring access and thereby potentially setting a somewhat concerning precedent

for how the June report may be used, and future reports, as well.

So given what we believe is an unintended outcome, we respectfully request that the Commission consider the following, and I hope I heard correctly. I think, Diane, at the beginning, you mentioned that the Commission would be submitting comments on the regulation, so we are encouraged to hear that, if that is the case --

CHAIR ROWLAND: Correct.

MS. MORESCA: So we first ask that the Commission formally ask -- formally clarify to CMCS that its first report was intended to serve as an overview and a baseline for measurement and should not be considered recommendations to the Federal agency.

In addition, it is significant that the Commission's work is highly valued by CMCS, other Federal policy makers, and other stakeholders, and we note this is particularly important given that the agency has indicated it will be issuing separate regulations on payment access and network adequacy in the Medicaid managed care program in the near future, probably similar to the March 6, 2011, proposed regulation for the fee-for-service program.

So we hope that the Commission will stress in its report that much of the data and research on managed care is out of date, and I heard that raised by several Commissioners and presenters and the staff, as well, so we do hope that comes across very clearly in the report, and that it would be especially misleading to use -- given that fact, that it would be especially misleading to use the data and research as the basis for a future rulemaking in the very near term.

Finally, I did want to reiterate that NAMD is very willing and -- NAMD and the States are very willing to work with the Commission as it develops recommendations to policy makers in the future and

specifically as it assesses and develops recommendations on payment and access, so thank you.

CHAIR ROWLAND: Thank you.

MR. KAUFMAN: Good afternoon. My name is Jim Kaufman. I'm with the National Association of Children's Hospitals.

First of all, we'd just like to thank all the hard work of the Commission on looking at access to care. And I have to admit, I loved the discussion this afternoon about how to improve data overall for Medicaid because that is one of our biggest challenges.

Also, publicly, we'd like to thank Lu Zawistowich and her team for spending time with the staff at the National Association of Children's Hospitals to better understand children's health care.

As you were talking this afternoon, Medicaid is a huge issue for children's health care, and that is why we strongly supported the creation of this Commission, because not only is Medicaid the biggest payer for children's health care, but when you look at children's hospitals, it is our biggest payer overall. The average children's hospital, 56 percent of their inpatient days are covered by Medicaid. And then when you look at the fact that Medicaid only covers, on average, 79 percent of the average cost of care, that is a big issue, and that 79 percent includes DSH payments and does not include the cuts that States have adopted in provider payments in the past two years. So that is a huge impact on children's hospitals overall.

Also, we would like to point out that when you look at Medicaid, we believe it has a big impact on access overall for children not just covered by Medicaid, but overall. The reason is, when you start to look at things, we always talk in children's health care that children are not just little adults, and that is a reminder that children need different health care services than adults. But it is also a reminder that children's health care systems are different.

When you look back, there has been a lot of discussion over the years about the shortage of primary care providers in adult medicine. Well, in pediatrics, we do have regional shortages of primary care providers, general pediatricians, but our real access to care problems is actually in pediatric specialty services.

When you look across the country, children's hospitals report vacancies of greater than 12 months for numerous pediatric specialty providers. But then you can just use one great example. In Montana, St. Vincent's Children's in St. Vincent's Hospital has been trying to recruit a pediatric surgeon for over two years and they still haven't been able to fill the position. When they are successful in filling that position, it will actually double the number of pediatric surgeons in the State. There is only one pediatric surgeon in the entire State of Montana right now.

We believe this is important, because when you really look at it, Medicaid impacts those decisions of young providers. Medicaid is the biggest payer for children's health care services, so that young physician that's coming out of medical school and is looking at, where do I choose? What specialty do I choose? Knowing that Medicaid is your biggest payer and knowing that, on average, your biggest payer is going to be paying you 30 percent less than Medicare for the exact same service, that creates an economic disincentive not to go into pediatric specialty services.

We believe that decision by Medicaid, paying so poorly, affects not just children covered by Medicaid, but children overall, because that is a huge shortage. And you see that play out when mom and dad are trying to get that appointment, for a pediatric neurology appointment, and it is taking nine weeks to schedule an appointment. That is just not Medicaid. That is everyone. That is the average appointment time that children's hospitals are reporting for that specialty when their benchmark is actually two weeks to schedule an appointment. That gives you an idea of the importance that Medicaid plays, not just in

children that are covered by that program, but overall services.

And that is why we thank you for your time, all your hard work in doing this, and we look forward to working with Lu and the entire Commission on how to improve access and how to make sure children's health care services are reimbursed appropriately. Thank you.

CHAIR ROWLAND: Thank you.

Other comments?

[No response.]

CHAIR ROWLAND: Well, I want to thank everyone for joining us today. Your comments are duly noted. I think that one of our earlier discussions focused on the fact that we were hoping that there would be a task force on the workforce that would help give us some guidance, but certainly the specialty issues are on the top of our agenda, as well as the primary care issues as we look forward at access to care, and certainly we will be making comments to the Department on the access reg and stressing the role that the framework played for us and for us as a model, but that this was not something that we did as a recommendation for the world to use. But we are also honored that people would take a look at our framework and think that it does pertain to some of the many issues that need to be assessed as one tries to look at access and payment.

But as a start-up, we felt we needed to develop our own framework for how to assess our charge of looking at payment and access to care for the Medicaid and CHIP populations and we see the framework as something that's evolving and that is part of our evolving analysis.

So I thank everyone for joining us in this room with us today and we hope you will find the June report to be a useful document that looks at managed care and at many of the challenges and that is also a

foundational document to at least show us where we are today and begin to lay the groundwork for analysis in the future.

Thank you very much. We stand adjourned from our public meeting.

[Whereupon, at 5:18 p.m., the public meeting was adjourned.]