MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

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National Guard Association of the U.S.
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Washington, D.C. 20001

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12:30 p.m.

COMMISSIONERS PRESENT:
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AGENDA DAY 1 PAGE

AGENDA DAY 2 PAGE

P R O C E E D I N G S [12:30 p.m.]

CHAIR ROWLAND: If we could please convene. Welcome to this meeting of the Medicaid and CHIP Payment and Access Commission, and thank you for attending this session. We are finishing what is our first and very full year of activity, going from a start-up in September of last year to a Commission that has come together with terrific assistance from the great staff that has been hired to produce the two required reports for the Congress. We hope that our MACStats and our reports have been helpful at providing a foundation for assessing and looking at the role the Medicaid and CHIP programs play in health care delivery and coverage today.

We are now setting forth on our next set of issues and have convened today to really begin to talk through some of the issues regarding Medicaid and value and value purchasing and also to begin to frame some of our priorities for the coming year.

I'm going to ask Lu to start by giving you a very quick update on some of the basic facts that we are trying to put together in MAC Basics that will be coming out over the course of this fall and into next winter so that you can have an assessment of where we are going in terms of trying to lay out another set of issues for consideration. These basic facts will be the framework on which we build our analytic agenda and, moving forward from that, the recommendations we'll be making in the future.

So with that quick review from Lu, then we will get into discussing our priorities for the coming year. Thank you.

DISCUSSION OF MACPAC'S 2011-2012 PRIORITIES

* EXECUTIVE DIRECTOR ZAWISTOWICH: Thank you, Diane. The staff has been working diligently over the summer, and we've prepared a series of foundational papers that will review key issues within the Medicaid and CHIP programs. Our goals are to have a series of these basics come out in the fall and winter, and let me just quickly go over some of the ones that are currently in progress and those that

will soon be developed.

To be released in the fall are a series of MAC Basics that will focus on Medicaid's role in serving individuals with disabilities, a primer on CHIP financing, an overview of drug payment policy, a primer that will look at Medicaid fee-for-service provider payments and the administrative process, an overview of federal and state program integrity efforts.

For the winter and early spring, we envision continuing on this work with an overview of Medicaid provider payments, an overview of Medicaid financing, a review of Medicaid's role in serving dual-eligible beneficiaries, and also a primer that will focus on Medicaid and quality measurement within the Medicaid program.

In the winter we'll continue with work on managed care for the dually eligible populations in Medicare and Medicaid. We'll focus on Medicaid managed care payment policies, including risk adjustment. We'll look at specific programs relating to the dual eligibles, including the Medicare savings programs, and we will review how dually eligible individuals become dually eligible for the Medicare and Medicaid programs.

Pregnant women and children continue to be an important part of our charge, and we will also be looking at Medicaid and CHIP coverage of pregnant women, along with Medicaid and CHIP coverage of infants.

We had started last year a series of analytic efforts, working with our contractors, focusing on access and health care service utilization, and we'll continue those efforts with a series of research briefs that will provide information on access to care across various population groups.

We also started last year to begin to look at various data sources, both at the state and federal level, to determine ways that you can measure access, and what we will provide this year is a compendium that outlines those data sources that are currently available that can be used to measure access.

So we are excited about using this as a basis for moving forward in our analytic efforts.

CHAIR ROWLAND: Thank you, Lu, and based on these reports and moving forward, we intend to try and take on some of the bigger and more challenging issues within the Medicaid program. We've talked a great deal in some of our earlier meetings about the role of managed care. Certainly one of the big questions that the Commission will be examining is to what extent are the states using managed care, how do these models vary, what are some of the quality and access outcomes from the use of managed care, and how does the extension of managed care apply to some of the more disabled populations that are now the focus, and as Lu noted, and how will managed care play out in terms of care for the dually eligible population where coordination between Medicaid and Medicare is required.

We've also, obviously, as the Affordable Care Act comes into implementation, begun to look at some of the regulations coming out from the Affordable Care Act, and one currently on the table is, of course, the eligibility regulation. And so the issues about streamlining eligibility, about how to focus eligibility redesign, getting ready for 2014, will also be among some of the major challenges the Commission will take on.

I think that one of the topics that we have all struggled with is what do we pay for and what do we get for what we pay for, and so payment is part of our name, it is part of our charge. And I think we're going to really have to focus in this coming year on what are we paying for, what value are we getting, what quality are we getting for the services, how does the delivery system as structured affect the ability to get the right set of services to the individuals who are covered by the program, how do we really best manage the care for those who are very high need and high cost, how do you integrate some of the services between Medicare and Medicaid for the dual population; but we also have really identified looking at the population with disabilities who rely on Medicaid as their sole source of coverage as a particular population of interest. And that will include, of course, looking beyond the classic medical benefits to make sure we're looking at

some of the oral health issues, to make sure we're looking at some of the mental health issues that can be very challenging for the Medicaid and CHIP populations, and to try and figure out whether there is a direct link between payment levels and access to care or what are some of the other factors that influence access to care, as that is another part of the name they have given us as a Commission.

I think that what we have tended to focus on is how to make sure that the benefits that are being promised through this program, that the eligibility does not convey to an empty promise, that the eligibility and the expansion of eligibility under health reform will really convert to meaningful access, and how do we actually measure meaningful access. As you may recall, we do have a charge in our statutory responsibilities to develop an early-warning system. We have been trying to think who we're supposed to warn and what we're supposed to warn about. But in that process it really is looking at where are the gaps in care and where are some of the individuals who are eligible for these programs not necessarily being connected to the range of services.

A great deal of the emphasis on looking at access and payment levels has focused on the fee-for-service side of Medicaid, yet in looking at, as our March report showed, and the June report especially, the distribution of how many of the Medicaid enrollees are now in managed care, we really want to focus as well on the role of managed care and how some of the changes there could affect coverage.

And, finally, as we begin our discussion today, we really believe that one of the goals of our Commission's work and one of the analytic pieces we have to pursue is how do we really go about improving health outcomes for the population that depends on the Medicaid and CHIP programs, how do we value the services that are provided, and how do we integrate quality of care.

So those are some of the challenges that we have pulled together in our thinking about where we would put some of our focus on in the coming year, but I welcome the other Commission members to also comment on how, as we struggle to put together our 2012 agenda, they are reflecting on some of the

challenges. And first I would ask David as my Vice Chair to make some opening comments as well.

VICE CHAIR SUNDWALL: Well, thank you, Diane. You've given a good overview of where we've been and where we are now. We have this very long menu of options for us to consider, and just this morning I was getting a bit dizzy trying to think of how on Earth we make some really good choices on priorities to address.

I think it behooves all of us just to acknowledge the context we're working in, extraordinary times in Washington with the deficit, with the budget pressures. I have said many times and believe sincerely that as they wrestle with the budget, that is going to require Medicaid reforms, and we know they are both at the state and federal level -- all the more important that there be a Commission like this where there's reliable, trustworthy analytical work to inform their policy decisions. And we certainly are walking that fine line trying to figure out how to be most helpful to Congress and also to States because they are struggling. Having been a state health officer in Utah for the previous six years where we had Medicaid to deal with, that was the most contentious budgetary problem, but also trying to figure out what is the state role and what can they afford to do.

So this is important work we're about. We really do need the help not just of my fellow Commissioners but from the public to guide us and give us pointers on how do we best help Congress in these very serious budgetary times.

Just a footnote I will add because it came to my attention at a recent IOM meeting that I serve on on integrating public health and primary care, in our deliberations to prepare a report, we keep coming up with the importance of financing -- good timing, Gail. I was talking about financing -- and how the leverage that Medicaid has or potential leverage in improving population health and addressing public health issues, because both with current leadership at CMS, Dr. Berwick, and Tom Frieden at CDC, there are some very clear imperatives on what we ought to be doing to improve population health and some top priority

public health issues.

So I would hope that in our efforts we figure out a way to make certain that we are using Medicaid dollars to do not just care for individuals but to improve public health.

Thank you.

CHAIR ROWLAND: Okay. Well, then Gail does have perfect timing because the next and first session we wanted to have today really does get at given Medicaid's role as a major health care payer, Medicaid state agencies are seeking to develop policies that promote value but often face challenges in understanding how program design and policies can achieve value at both the state and federal level. So we've called Dr. Wilensky to come today to offer a unique perspective on assessing value in the Medicaid program from within the context of other health care systems. It is clearly a pleasure to have Gail Wilensky here with us today, the John M. Olin Senior Fellow at Project HOPE, but as we all know, a member for many years and chair of the Medicare Payment Advisory Commission and also the head of the Health Care Financing Administration. We hope that we will be able to post after this meeting Gail's slides on our website. We apologize for not having copies for the public right now, but they will be available on the MACPAC website after this session.

Gail, thank you for joining us to kick off our discussion of getting value from Medicaid and value from other programs as well.

ASSESSING VALUE IN MEDICAID

* DR. WILENSKY: Thank you for having me. I've only occasionally been on this side of the table for the various commissions so it's nice to get the vantage point from here as well. I am glad you were able to indulge my last-minute decision to include slides, and I know you have them and I'm pleased you'll be able to post them so other people will have access to them as well.

This is a big issue and Lu asked me to give an overview, so hopefully I won't step on other

presentations; but, rather, just set them up so that there will be some basic facts that we can all work from.

First is just a reminder of some very basic Medicaid facts. Again, I know some of you live and breathe these numbers all the time. For others, it's not quite so much. Your everyday activities so I just wanted to make sure we were all roughly on the same page. I have noticed that precisely which numbers you use depends on who you crib from. But I think the basic message is pretty much the same no matter where you get the numbers.

The first is to remind people about the basic numbers, about 68 million. Most of them currently are on some type of managed care, but these are mostly the moms and kids part of Medicaid, rather than where most of the money is spent. An ampersand got left off that slide or the middle of the slide.

But most of the people who are in Medicaid managed care are the moms and kids, the acute care users of Medicaid services. Most of the elderly and the disabled are still in fee-for-service Medicare and concerns have been raised as a result, particularly for the duals, that they are subject to fragmented care and uncoordinated care, as I will indicate as we go through this.

I don't mean to suggest that just because you are in Medicaid managed care means that you necessarily have high quality coordinated care. But if you're not in managed or coordinated care, it is very hard to have care that is coordinated, and this is especially problematic for the very high users who are the duals and the aged and disabled. There's a lot of overlap. I'll mention that in a minute. But they're not completing overlapping categories.

The aged and disabled are only a relatively small portion of the population in terms of numbers, but are and have been, for as long as I can remember seeing these numbers which is at least the mid-1970s, relatively a small number of users between a quarter and a third, historically, but between two-thirds and 70 percent of the dollars, historically, as well.

The dual eligibles are roughly about 9 million people. They are very high users of health care

services, spending more than $20,000 a year. They account for a completely disproportionate share of the Medicaid dollars. There's some overlap with the disabled population, but they're not completely overlapping by any means.

A third of the disabled are duals, but that means that two-thirds of the disabled are not. There's also some differentiation for duals that are under 65 and over 65 in terms of the kinds of services they use, so you have to be a little careful about having too broad of a brush when you look at them.

The basic message, however, remains the same, which is this relatively small number of people who use a disproportionate amount of the resources and are rarely enrolled in what would be regarded as full coordinated care programs. Less than 2 percent in terms of full managed care or coordinated care.

There are some states that use primary care case managers and bring some coordination to fee-for-service. There's a lot of debate about exactly how much coordination occurs in these programs. As is true with almost everything in Medicaid, it varies among the 50 states. And so, it's hard to make generalizations.

There is an increasing interest in managed care or coordinated care coordinated care. It is being in part driven by spending and cost concerns, particularly because of the large expansion in Medicaid coverage that is scheduled to occur in 2014 as a result of the Affordable Care Act.

It is increasing the interest and focus on both improving quality, but especially in terms of improving value. It requires, among other things, performance measures. It is not something, these performance measures, that have generally been used in fee-for-service, although the Secretary was directed, as part of the Affordable Care Act, to develop some performance measures for the fee-for-service population in Medicaid.

It is especially important for the duals and the disabled population that credible, reliable performance measures are developed and in use. There has rightly been concern about just automatic

application of managed care which is geared to the acute care population, to the disabled, and dual eligible populations because their needs are so different.

But again, it has been equally clear that leaving them in their present state has resulted in very high spending, which is a concern in and of itself. But even more importantly, indications of inappropriate use of services, lack of quality, and lack of focus on outcomes.

The potential savings and quality increases for the duals and the aged and disabled that aren't duals varies. I saw, I think in the Kaiser Family Foundation, this morning a report, I saw them yesterday. Ken Thorpe's estimates. I've used two different estimates that I've seen, one from Ken Thorpe, one that was provided to me by United Health Group. They're both in the same kind of general ballpark.

Ken Thorpe's estimates are roughly $125 billion of savings over ten years, two-thirds Medicare, one-third Medicaid. United Healthcare, United Health Group's estimates were Federal savings of over $100 billion for ten years. That would assume full enrollment and evidence-based managed care plans, and an integration between Medicare and Medicaid, full integration between Medicare and Medicaid.

There are many challenges involved in terms of moving the dual eligible and disabled and aged populations into managed care. I'm talking mainly about some of the performance measures, and those challenges, but there is, for me as an economist, an important financial incentive challenge as well, and that is that the states would get to do most of the work and the Feds would receive most of the savings because of the dominance of Medicare combined with the Federal share of Medicaid.

And so, trying to come up with ways that might incentivize states to take this one more seriously, not that they would not also benefit, but whether they would benefit enough to want to make the investment in trying to bring this population, which is not used to being a part of coordinated care, making their advocates comfortable and also having the providers that treat them comfortable, that this was going to improve the quality of care and not just offload spending onto somebody else.

There are many performance and measurement challenges. I was looking, when I was getting ready for this yesterday -- and I'll come back to this towards the end of my prepared comments -- at some slides I had put together on pay-for-performance, next steps, and paying for performance, a progress report, and one of those was written December of 2006 and one of them was April 30th, 2007.

I think I see a little progress from what I was noting in that time period, but not so much progress, I will say. There are better performance measures for managed care than there are for fee-for-service. Part of is that the law has required these performance measures for managed care for some time that has driven some of the investment.

But frankly, it's easier to do. The nature of a managed care plan is that you have somewhat of a team approach and you are better able to both look at process, but particularly to be able to measure outcomes, at least outcomes such as they exist in most of the reporting forms on a managed care plan, in a way that is much more difficult to do in fee-for-service where a great many individuals may be involved in the care of a person, particularly a person with a complex medical condition, and trying to measure outcomes or even processes has been much more difficult.

These measures, as I've indicated, are less developed for fee-for-service, although there are a number of states that report some performance measures for fee-for-service so it is not starting dual eligible novo. The place to start these ideas came from a report that was done for the California Health Care Foundation last year, a very good report and I commend it to you if you haven't looked at it thus far.

It was to start with the HEDIS measures. We understand that that puts an awful lot of emphasis on process and less on outcomes, but it is, nonetheless, a place to start. It will be particularly important for the dual and disabled population to be sure to add behavioral health measures and other specialized measures which are important for all populations, but are critical for this population.

It will be important to involve the various stakeholders. And because this is still a relatively new

activity, it will be important to make sure that there are resources and audit functions so you can go back and check to see how it is working.

When you look at what is going on elsewhere, and I was asked to share a little bit of what is going on in both Medicare and the private plans, although there are other people who you'll be listening to today that can do that as well, I wanted to give a sense about where we are.

As you will see, this has been a long process to get to where Medicare is now, which is ahead, but not hugely ahead, I will say. The initial strategies all focused on pay-for-reporting. I was surprised at that, as an initial strategy, when it was included in the Medicare Modernization Act in 2003, that hospitals would be paid for reporting on quality.

My attitude at the time, which I was very outspoken about, is that this ought to be such an important requirement that if hospitals wanted to get Medicare funds, it ought to be part of the process. But I have since recanted and understand that paying for reporting allowed the voluntary reporting of a third, 33 percent roughly, to go to 90-plus percent.

And since we had gone as long as we had without much reporting, having a few years where you pay for reporting seemed like not such a high price to pay. After all, physicians started somewhat later because their ability to report is much more varied, particularly difficult for the very small practices, somewhat less difficult for the larger, especially multi-specialty practices.

They also started with a voluntary system, the Physician Quality Reporting System, PQRS. It is now only in the incentivizing stage. As of 2014, a penalty phase will kick in for those who don't report.

As many of you know, the early pay-for-performance activity for Medicare was the premier demo which allowed for higher payments for those hospitals on a voluntary basis that reported and had high quality reporting. And then the value-based purchasing proposals were included in the Affordable Care Act.

They start first for hospitals in 2013 and then there will be a physician component starting in 2015. So it has been a gradual, first get institutions and then individuals to report on quality measures, get them comfortable, have a period where you can debate and assess the credibility of the measures themselves, and after some period of time, move to penalizing those that don't report and then actually moving to paying on the basis of these quality measures.

With regard to the private payers, they are in a slightly different position, in large part because unlike Medicare, affectionately known as the big gorilla, private payers have far less of an ability to impact the market in most areas, and therefore, they have less ability to actually change the practice patterns.

What they are primarily doing is trying out various performance-based contracts that are linked to quality. What has been more frequent is to have bonus payments for fee-for-service based on efficiency and quality measures, and sometimes to link the plan characteristics, particularly the co-insurance characteristics, to the use of the efficient, high-quality providers by lowering co-insurance for those that will use the so-designated provider group.

As I've indicated, trying to change the practice pattern since we've known -- since the introduction of DRGs is most individuals and institutions, once they adopt a new way of doing something, do it without differentiating who the payer is.

So in this case, unless you're in an area where there is very large dominance by a private payer, it has been hard for the payers to get the physicians or hospitals, for that matter, to change their practice patterns, and there has been a lack of uniformity in terms of what the best measures are, and not surprisingly, a lot of reluctance to change anything about your practice if there isn't a clear agreement that these are the set of measures that are going to be used.

I have one last slide. This is what could be the opening for a lot of discussion, but it periodically comes up in discussions, and I think as frustrated as most of us are about the current way that we are paying

without any differentiation for either value or quality, there are a lot of questions about whether we know what we're doing in this regard, particularly when it comes to pay-for-performance or value-based purchasing.

I was in a small group discussion on Monday with Bob Berenson, who has been a vocal skeptic from the very beginning about pay-for-performance, and he once again raised many of the concerns that he has raised in the past, but he is not alone on this issue.

There are a lot issues that have been raised. One is, I've already mentioned is whether or not we have way too much focus on process measures with enough indication that process frequently doesn't predict outcome to be worried about what we are doing in terms of slanting the change in how care is being provided.

There has been a lot of concern, including in the physician practice demo that was just completed by CMS, as to whether or not there is too much teaching to the test that goes on. That was a case where there was very substantial improvements in quality over the period of the demonstration, even though there was high quality to begin with, but there still was substantial improvement in the treatment of diabetes and a number of other chronic diseases over the life.

But whether or not there was too much teaching to the test that went on, even with these ten well-known groups. There has been issues raised, and Berenson has raised this as well as others, as to whether or not when we see responses like what we saw with regard to the physician group practice demo or the premier demo, whether or not it was the payment that actually was the causative factor, whether or not there were just secular increases in quality that were going on, whether or not public reporting was as important or more important than the actual payment component, and whether or not there was catch-up by the other hospitals, in the case of premier, over time so that the initial bump-up that looked like it was responsive to the incentives was actually not, in fact, a real factor.

And in general, a question of how evidence or non-evidence-based our work on pay-for-performance and value-based purchasing actually is. And concern that with all of our discussions about the importance of evidence-based medicine, this is an area where there is precious little evidence to date in terms of what will result.

So those were the comments that I wanted to make before our discussion. It's an area where it is ripe for attention, particularly for the dual eligibles and aged and disabled. They're very high spenders. There is evidence that they do not get good quality care, that it's very fragmented and uncoordinated.

But we do need to understand that you will be venturing into areas where we are even lurking more into the unknown than is frequently the case, both in terms of how to do it, what should be done, and most importantly, how to measure what's happened so that we can say either we are moving in a better direction or worse direction or staying roughly the same. All of these ought to be regarded with caution.

I chaired a pay-for-performance subcommittee with Bob Reischauer that was part of a three-year Institute of Medicine study in the 2005-2006 period, and whenever we would have a one- or two-day meeting which would end up having most of us wondering whether we had any business going forward with these notions, it helped to step back and remember that for decades, we have been paying without any regard to quality or efficiency or outcomes, and we know we don't like that as a basis.

So as daunting as it is to go forward in this new direction, the status quo really is unacceptable, and is especially unacceptable to the very high users, sickest part of the Medicaid population. Thank you.

CHAIR ROWLAND: Thank you very much, Gail. That's really opened what I hope to be a very in-depth discussion and also help launch some of the direction we want to pursue in our work over the coming year, to really look at how to get better value from the Medicaid program, the role of payment reform, not just payment rates, and promoting access and quality. So I open up to the Commission for any questions and comments they might have.

VICE CHAIR SUNDWALL: Just quickly, Gail, thank you very much and good to see you and so glad you could join us today. Are you aware, on your slide when you talked about Ken Thorpe's projections of savings in this United Health Group, when they enrollment in evidence-based managed care, what comes to mind to you when you hear that? Are there exemplary plans or ones that we can use as prototypes or such?

DR. WILENSKY: Well, I think the issues are how well integrated the services are. Ken used the term "coordinated care." When I was the HCFA administrator, I kept trying to get people to stop using the term managed care since most of us don't like the concept, that we're going to be managed, and talk about coordinated care, which I thought was the end objective of what was being raised.

So we know some things. We know some things in terms of how physicians relate to each other. We have some knowledge about the need to share information, either electronically, which is the desired way, or some other way, to have information shared about the practice, something about the actual use of best practices and protocols.

And we do have some models that appear to have worked well, particularly Intermountain where you are most familiar probably; Geisinger where I'm also a director; and other fully-integrated, Kaiser and the work that they have done, where you see the ability to have a team approach, the providers of care are integrated, and that there's an information sharing.

But the question of how far we get when we talk about evidence-based varies because a lot of where we're going now is pushing the envelope. I mean, all of the meaningful use IT activities are pushing the use of what it is we know will actually work. Some components are a little easier. For example, electronic prescribing as a way to improve patient safety. I mean, that's an area that has been researched more than some other areas.

So I think the answer is there are some parts of that are more evidence-based than others. It was

really -- the statement, as I read his report, is a very interesting report, was the recognition that pure capitation without engaging in other changes and how providers interact with each other does not result necessarily in integrating care.

And in the case of the United Healthcare, I have their report, but I didn't go through it quite as much as I did with Ken's report. It was requiring a full integration of these two programs, Medicare and Medicaid, which has not clearly been possible. We'll see what happens with the new integrated office and the proposals that have gone out as to whether or not that will actually be possible in the future.

VICE CHAIR SUNDWALL: I just want to say one follow-up to that and that is, I'm sure you're aware of the enthusiasm states have for this concept. In Utah, they passed a law that will, quote, reform Medicaid, which is essentially requiring most recipients be in a risk-based managed care.

But their extrapolation of potential savings is $800 million over ten years. So I call that faith-based policy and I hope they're right, but it's kind of -- there's a lot of hope being placed in this concept and we'll see how it plays out.

DR. WILENSKY: There is -- you've raised something that I noticed in one of the reports I was reading in the last couple of days, a real concern about whether CMS is going to be able to handle the waivers in a timely basis. Now, this is like for 20 years, I have been hearing complaints about the need for HCFA/CMS to streamline the waiver process.

But as I'm sure you know, having mandatory participation in managed care requires a waiver. So every state that thinks this is what they want to embrace has to get in line for an agency that has a lot on its plate. So hopefully, this is an area that will be regarded important enough.

I saw there was a harangue by Max Baucus yesterday with regard to when exactly CMS is going to get going with regard to the dual eligibles. So there's clearly some political pressure being applied. But it is not only faith-based as to what will happen, but being able to be in a position to actually carry out

whatever the state wants is going to require cooperation from the agency as well.

COMMISSIONER RILEY: High tech. Hi, Gail. Nice to see you again. You mentioned Geisinger and Intermountain, and I'm thinking, part of the concern I think many of us have about quality measurement is that we measure widgets -- your comments about HEDIS. How much should we spend attention -- if we're to make recommendations about going forward, how much should we spent time on better measures for the current system? And how much should we recognize that the best way to get value might be to restructure payment and delivery? Might it not be better to think differently about patients at a medical home, the ACO demonstrations? And what would you advise us, how could we think about the service delivery and payment reform system at the same time recognizing the extraordinary financial constraints on Medicaid programs? Every time I hear ACO is almost the new magic bullet. Nobody can define it the same way as each other, and yet it's somehow the answer.

When I think of a state as small as mine, or any of us, when you think about integrated delivery systems, you think monopoly and high cost. So I'm trying to think about value in a different way.

DR. WILENSKY: You're raising some very important points. I had a short piece, a perspective in the New England Journal that went online last Wednesday, which was entitled something like "A Sobering View of the Physician Group Practice Demo and What It Says about ACOs." So I share some of the concerns that have been raised about whether ACOs are going to quite the panacea that we have assumed them to be.

I do think payment and delivery reform are critical to forward progress in terms of improving both the care and the quality that is provided. The problem and the tradeoff is how much do you invest in recognizing you are where you are, which is for these high spenders, mostly fee-for-service, and so there is some rationale for stopping what has almost been a free pass for where all the money gets spent and focusing some activities there and recognizing that good coordinated care, changing the delivery system,

changing how you reimburse for that care, which is much easier in a managed environment to reward the groups that are getting good outcomes, where you look at the clinical outcomes as well as the processes of care, is where you would prefer to be. But it really is going to be a balance because, as indicated, almost none of the high spenders are there now. And I don't know that we can just afford to look at where we want them to be and ignore where 98 percent of them actually are now.

So one of the areas which may not require large investments -- anything that is requiring any investment is a challenge, and especially a challenge in Medicaid because it's not clear where the states are going to get the money to keep up with the growth that they're experiencing now -- is whether we can do a better job of sharing information and best practices than appears to go on. This is, again, part of a discussion that came up on Monday.

I had thought there had been more of a clearinghouse on Medicaid directors than my colleagues who are probably better informed as to what has been going on in the last few years or the last five or six years than I am. But there are some states that are much farther ahead in this measurement in fee-for-service than other States. And there are some states that are using alternatives to or additions to HEDIS. Indiana is one, but there are a number of states that are using non- or additional measures to HEDIS, and more aggressively getting that information together and disseminated seems like a critical first step.

It's very hard -- it's easy for me because I'm not responsible for the budgets -- to say when we are spending so much money on this program for this small set of individuals to not be able to take what are relatively small sums to be able to circulate best practices and what we know about these measurements is just unbelievably foolish. But I don't have a constitutional amendment that forces me to get to a balanced budget and facing the kind of pressures that governors are facing. So it's probably easier for me to say that.

CHAIR ROWLAND: But clearly you're saying working on identifying some of these best practices would be a contribution that this group could, in fact, make.

DR. WILENSKY: Absolutely.

COMMISSIONER ROSENBAUM: Thank you for coming. Thank you for being here today. I have a question, sort of a follow-on from the issue that Trish was raising, and it gets, I think, down one step closer to the ground.

For the past several years, as part of the research we do on community health centers, we have been watching, with some alarm, actually, an extraordinary trajectory in Medicare beneficiaries. Now, this is great. Health centers certainly are positioned to do excellent work for Medicare beneficiaries. The trajectory that we're watching is within a ten-year period a doubling of the number of Medicare beneficiaries receiving care at health centers. Can't be explained by population, can't be explained by growth in low-income people, can't be explained by the growth in the program.

What we assume is going on -- we don't really understand it, and work has not been done to explain it completely -- is that there is a tremendous shift, underlying shift going on in where low-income Medicare beneficiaries get their care. Physicians who might have been in medically underserved communities are retiring. As a result of the 1997 change in Medicaid payment for duals, physicians may not be accepting dual enrollees anymore. So that's sort of this one issue.

A second issue is that one of the things that the Affordable Care Act called for is a restructuring of the FQHC Medicare payment system. And I'm wondering whether we should be focusing on the issue of Medicare beneficiaries who particularly live in medically underserved areas, which my guess is probably a disproportionate number of duals who live in medically underserved areas, and making some recommendations about what CMS and HRSA might do in the Medicare payment restructuring effort to both incentivize the building of high-quality primary care health care systems for dual enrollees and then

linkages between health centers and coordinated systems of care.

Ironically, of course, the recent ACO proposed rule cuts exactly against the grain. It leaves health centers out of -- leaves their patients out of the patient assignment system for ACOs. But I'm wondering whether we can really get where we need to be on duals if we don't deal with the underlying problem of the health care access itself and ask the Federal Government, for exactly the reasons you propose, that so much is being put on the states, to do something with the tools it has to try and lift up the quality of primary care and its integration with broader systems.

DR. WILENSKY: This is an area -- I don't know how much either history -- you don't have very much history, so I guess I may answer my own question -- but if there is either any history or interest in doing joint projects with MedPAC. This seems like it would be a good first example.

There was some history before MedPAC was created when I was chairing the Physician Payment Review Commission, and we had overlapping jurisdiction for the risk plan and also for some parts of graduate medical education, to do some joint activities, and this might be an area because it's -- both without knowing exactly what your charge is, but I could imagine that that would kind of pull you toward the edges of your charge, and your charge is probably quite bit enough.

But it might be an area where because there is so much that involves Medicare that you could get Mark Miller and Glenn to have some interest in having a small work group take on this issue. And I don't know what the particular rationale is for keeping the FQHC off of the ACOs.

COMMISSIONER ROSENBAUM: I don't think we can make progress as MACPAC on this issue until we devise a strategy for moving hand in hand with Medicare policy, wherever it overlaps, and the rationale was that because health centers, like other providers, like rural health clinics as well, are not paid on a procedure-by-procedure basis. The data are missing to ascribe patients to primary care.

Now, I consider this sort of a silly issue because everything that a health center does pretty much is

classified as primary care, plus they're now reporting procedure data. But it seems to me that if we -- we've got to deal with the fact that the competency and care for this most difficult population has to be a focus of our recommendations. We've got to build from the ground up to get to a point where there's something to connect into coordinated care, just because so many of the toughest patients are in communities where there's no primary care infrastructure.

DR. WILENSKY: Well, it may be something where you want to look -- I mean, I think, without meaning to prejudge too much, that ACOs are going to begin to consider enrollment models in the not too distant future, given what I've seen when they don't, and that would lend itself much more easily to an FQHC world where you can think about an enrollment model.

COMMISSIONER HENNING: I would just like to speak to FQHCs in that that's where I work as a certified nurse midwife. I think that we are basically an accountable care organization for primary care in that we provide a whole range of services -- dental, primary care; we provide women's health, including maternity care, and pediatrics. We have a pharmacy on site. We have a lab on site. We have an x-ray department on site. So from that standpoint, we are definitely very coordinated. Our major problem as an organization is getting the specialty referrals that we need because our patients are either -- you know, 50 percent of them have Medicaid or, you know, possibly Medicare or private insurance, and the other 50 percent have no insurance at all. Those are the people that are very difficult to get care for.

DR. WILENSKY: Well, the attraction of an ACO as I see it is just that it allows you, if you work better together, to share savings in a way that if you do it otherwise, you're violating the Stark regulation. So for other than if they're -- it would mean that a federally qualified health center could find a different way to interact with specialists, that's not your problem as I see it.

Now, if it would allow you more latitude in terms of how you interact with specialists and how you could potentially share savings with specialists, then it would become attractive. But the problem, at least

as I have seen it, which is that physicians are being asked to generate a lot of the savings, but under current payment models they don't get to share in the savings; and if they try to share in the savings, if they're not formally integrated, then they're violating some combination of anti-kickback and Stark. And so this was a way to be able to share savings when you're not formally integrated and not be violating that.

So I see that as a different issue for the federally qualified health centers, unless it would change how you interact with your specialists and allow you to share savings if you are not able to share savings. But it's pretty daunting to be an ACO. I mean, I remain unconvinced that this isn't going to be a PSO redux, for those of you who have longer memories. You know, you too can get to put in a lot of money to be able to measure your quality and to come join together and to take risk in year three before you know what's happening in year one and maybe have retrospective assignment and probably other things I haven't thought about yet. So it is like, okay, and, you know, what part is in it for us?

COMMISSIONER MOORE: On that same kind of idea, and reflecting back on your comments on most of the work being at the state level and most of the savings being at the federal level, and when you're dealing with dual eligibles, can you just reflect -- you're in a better position than I think most of us, having so much experience with both of these programs. Can you just reflect on how you -- some options for how that could be sorted out a little it better, both administratively and also from a policy standpoint?

DR. WILENSKY: I have long advocated the full integration of dual eligibles in a single Medicare-Medicaid program. It makes no sense whatsoever, what we're doing now, and precludes most activities, including a better shared savings than is likely to exist.

The constraint has been really the constraints on Medicare. States have traditionally had way more power to place Medicaid beneficiaries as they wished, although requiring usually or frequently some waiver by the federal government, which generally speaking has not been an insurmountable barrier.

The restrictions on Medicare have been far greater, which is obviously a commentary on our

attitudes toward different populations. But it makes no sense on any level to have these be separate programs, and it has just raised what have been to date insurmountable barriers to be able to do it smart, do it sensible for what is clearly the sickest, most fragile, frail population that we have. Whether or not there -- I mean, you could make some of the same charges as to why we have A, B, and D Medicare, which makes our other big public program the most fragmented delivery system of health care in the United States. So, I mean, it's not completely unique in this. I think unless we make a real integration of these programs, it will be very hard to solve the problems.

Now, if you do that, you have to raise the question of what happens with these mingled funds, and particularly in the current budgetary environment, it's going to be -- it is going to have to be demonstrated that both sides -- that is, federal and the State governments -- are better off with a shared arrangement than they would be without that shared arrangement. And that is likely to mean some amount of sharing of the federal savings with the states, but it's not likely to be a big amount or the Feds are going to balk. But it's hard to imagine that not happening when the Feds pay so much of Medicaid and all of Medicare. But the states are the ones that are going to have to do the work, and it really gets you to this issue about, you know, why were ACOs attractive, and it's that, well, the docs -- you know, this is something I've heard now at least 20 years: We're the ones that are always being asked to produce the savings, and nobody wants to share them. The hospitals get the savings, typically, or maybe the pharmacy may get the savings. We hardly ever get the savings. We're last down the chain, but we're going to do all the work and we're going to produce all the savings. That is not an enticing proposition, and this was a way to try to allow some of that.

And so it may be getting people to really think in the same mind-set, to recognize that, you know, we have struggled with this problem almost from the get-go, and that it is extremely expensive uncoordinated care for people who really can't afford that kind of misstep. But it will be -- I mean, it's

going to be crossing what have been very difficult silos, and so recognizing that that's what you're doing and trying to make the clear case as to why both sides will be better off is the only strategy that maybe will help you.

But if it's just -- I had read in one of these write-ups, oh, our great argument is the Feds should share some of the savings with the states. Well, that's not the way to put it. I mean, that is just strategically not the approach I would take. It would be by demonstrating to the federal government how much better off they will be, most of which will be their savings. But in order to try to motivate the producers of the savings, you're going to have to do some sharing.

CHAIR ROWLAND: Gail, could you talk a little bit about within the dual population, we know there are some who are institutionalized and some who are in the community. We also know that there's a substantial disability population within the duals as well as within Medicaid itself. How do you see some of those integration issues playing out for the different subpopulations?

DR. WILENSKY: Well, I think it's going to be recognizing that these groups have different needs, and they're going to have to -- they're going to need to be treated differently and, equally important, the performance measurements we use are going to have to be different for the different groups. The number -- and I haven't checked it. Alan Weil had mentioned to me when I asked him earlier in the weeks that about a third of the disabled were duals and two-thirds were not duals. So assuming that's roughly the proportion, you're going to have to deal with two quite distinct disability populations, and the duals who are under 65 and the duals who are over 65 are likely to have different needs.

If you look at where the savings are that are projected, they're basically in two places: one is far fewer hospitalizations, and especially readmits; and the other is far fewer nursing home admissions. And if you've ever been to a nursing home, you see -- and we're beginning -- sort of the good news of our advancement in medical technology is that people under 65 are being saved after major trauma, but they are

ending up in nursing homes that are geared for over-65 populations. And then in addition to every other problem you have, you have major issues with regard to clinical depression, which, of course, has all kinds of sequelae in terms of other health care needs.

So recognizing that we can't just say there are the duals and the moms and kids, but that there are these different populations and they have different needs and they generate different strategies, appropriate strategies in terms of their -- and different challenges. And we have to be careful or we will end up doing different but equally dumb things.

COMMISSIONER MARTINEZ ROGERS: I was just going to make a comment that as Denise was talking, you know, as we look at primary care physicians, the population, not many doctors are now going into primary care. Many of them are going to specialty areas, and even family practice physicians, I think in itself is going to be a barrier to some of the clinics that work with the underserved, in particular with the Medicaid populations, because that's something I know that the Commissioners Court is looking at.

DR. WILENSKY: It is possible that a couple of different changes that are going on may help this some, and then there are a lot of things we could do to help it along. To the extent that there is more movement to managed care and integrated care, there is an ability to change the relative salaries to some extent.

Now, you can only go so far away from the market, or you're not going to be able to hire, so you can't completely ignore what is out there. But it is possible to make some softening of the differentiation that exists in the most dramatic areas, which is fee-for-service medicine.

The second thing is for about the last decade, maybe decade and a half already, half of the medical school graduates are women; and while there is still a huge stock of males dominating, that will gradually shift, and there is indication that there are different interests in terms of the desired kind of practice and

practice style, and also different interests even among some of the male counterparts or cohorts of this same group, which may make some of the coordinated care/managed care settings more desirable, which in turn will allow for a somewhat different mix.

Finally, we're going to have to be a lot more creative in terms of who can provide what service. State scope of laws will constantly trip us up in this activity. It would be nice if some parts of organized medicine would spend less time worrying about whether a doctor of nursing is going to confuse patients and more time thinking about how to have more advanced practice nurses and nurses at various levels and the mix of services that primary care physicians and nurses and other health care practitioners can provide.

But we don't have anything like the right mix, and I don't anticipate we're going to have enough primary care doctors, no matter what we do, in anything like the near term. And we're going to have to get more clever as to what is it that has to be done by whom and how do we entice more people into those areas.

I remain frustrated that we have not had serious loan forgiveness tried since the early 1970s when tuitions were low and medical practice incomes were high and growing. And for the last 20 years, we have had high medical school tuitions and pretty flat physician income -- high but not growing quickly -- and that gives a lot more potential and leverage if we want to use it, again, to help us get into a better position. But it's not an easy fight.

COMMISSIONER MARTINEZ ROGERS: I think Rebecca, the new director of the Commissioners Court, is looking at bringing in different ways of how they're going to move forward, the marketing that they're going to be doing in terms of loan repayments, what they're asking for schools to do, and also acknowledging the fact that DMPs are coming. Whether, you know, MDs want it or not, we are coming. And so I think that we will see some changes, but it may not be fast enough.

DR. WILENSKY: Well, like the issue of payment that we were talking about earlier, you can't

divorce this subject from the delivery system reforms that go on. If you look at the mix of health care personnel in the military or in integrated care facilities, it is very different than what you see in private fee-for-service practice. So it's why when we see projections about physician shortages in the future, my first question is: What kind of a delivery system are you thinking about? If you're thinking about the one we have, we obviously have a huge physician shortage heading our way. But I'm not sure why you would want to put in all the kinds of subsidies and changes to continue what everybody agrees is an incredibly inefficient way to provide health care that costs too much and does not deliver the kind of quality we want. And if you talk about different delivery systems, we may still have shortages, but they're likely to be very different and much more spot in terms of areas, geographic areas or specialty areas, and look very different in terms of surgical specialties and some of the medical subspecialties, because, again, when you look at the use of some of the specialties per population covered in Intermountain and Kaiser and Geisinger, and especially in the military, you see very different mixes than what you see in the private fee-for-service world.

CHAIR ROWLAND: Sara?

COMMISSIONER ROSENBLUM: I guess putting all these thoughts together then, my question is, if we are going to try and move toward the potential of a far more integrated Medicare and Medicaid financing stream with more control of the level of service delivery, both in terms of state control and system integration.

Don't these issues of organization and staffing suggest that one place the Commission might spend some time is on the performance benchmarks that one would want to see in any state that's going to, in fact, try and move this forward?

In other words, that you want to start with the states that have been the most progressive about licensure, that have been the most thoughtful about recognition of levels of care in long-term care to, in fact, allow the minimum level of medicalization of a care setting while still satisfying the Medicaid

requirements so that you can deal with room and board and 24-hour assistance without having it be more intensive than it needs to be, that have been the most progressive on home services, on personal attendants.

In other words, we should be able to identify those attributes of a state that is oriented toward building what you are suggesting if, in fact, everybody is ready to start down a more ambitious road of financing integration.

DR. WILENSKY: Well, you have to be careful. This is exactly -- the dilemma of what you're suggesting raises a recollection of exactly the dilemma you get into in pay-for-performance. You have two goals. You want to reward the good guys, the high achievers, and you want to incentivize those who show a desire to improve.

And so, it is going to be the tension between recognizing the importance of achievement, attainment, and recognizing the importance of improvement. And you need to be very careful that you don't so wait that you make it impossible for those that aren't in the top quartile to feel like they can make a difference.

So it's easier and tempting to go to where they have shown the most progress on their own and the most investment in terms of getting to where they are, but you have to be very careful that you don't dissuade activity, because in some ways it's much easier to actually, if you can get the right motivation and break through the political barriers, to get improvement down in the groups that haven't been at the forefront in all of these activities.

So it is -- I mean, it's going to be a tension and, as I said, exactly the kind of tension that you have in terms of thinking about pay-for-performance. How do you weight achievement and how do you weight improvement, and sort of the obvious answer is you've got to consider both and it's all about how much weight you give and how you allow that over time.

If ultimately what you want to do is to be bringing the mean up over time so that what was the

lowest quartile starts getting closer to what had previously been the mean of the whole group. But it is going to be a tension that you'll have, particularly in Medicaid because you're working with 50 programs.

But again, a lot of it is without the measurement, you'll never know what you're doing. And I have been long willing to give up some of the rigidity and process -- it's a discussion you and I have had over about the past 30, maybe 40 years now -- in return for good outcome and performance measures.

That's the quid pro quo. And willing to give a lot on flexibility about how you get there, if what you're able to demonstrate is convincing. Now, if it's not, then you lose whatever comfort, even if it's not much related to outcome, you get from having good process. But clearly what you really want to do is to have much more focus on outcomes.

And the field in general has really improved dramatically in the past couple of decades. So we are in a much better position than we were. It is unfortunate that the most serious areas are the least developed. So it's the chronic care, the people with four or five chronic conditions, at least one of which is behavioral health. And it's the areas where we know least what we're doing or even how to measure so we can be sure we're moving in the right direction.

But we've got to start focusing much more on going where the money is, and in this world, it's the combination of duals and aged and disabled otherwise.

CHAIR ROWLAND: So we should follow the money and we should pay for reporting.

DR. WILENSKY: You're talking to an economist. What do you expect?

CHAIR ROWLAND: Andy?

COMMISSIONER COHEN: Recognizing your point that where we are today is 98 percent of dual eligibles, if that's the number, are in fee-for-service systems, at least for a significant portion of their care, I wanted to ask you a little bit more about one small bright spot in the presentation around the issue of performance measurement where you said measurement around managed care is somewhat more developed

and stronger.

And one of the things we've talked about here is just the capacity in different states in different sort of expertise within states to contract with managed care to develop different kind of performance measures for managed care plans, et cetera. Can you talk a little bit about some maybe best practices on performance management -- sorry -- performance measurement in managed care in particular?

DR. WILENSKY: Well, it's an area where we really need to get serious about the sharing best practices world. In rural health care, there have been, at least in the past decade, periods where there have been grants made to states to help them be able to implement best practices, and this really seems to be the kind of area where -- I mean, there seems to be an awful lot of grants coming out of HHS to states now. Maybe it just looks like that to the casual observer.

This just seems an area that has been ongoing for so long to be able to share best practices -- again, you're not talking about big money because you're not talking about inventing these performance measures as much as you're talking about sharing the performance measures.

And where you want to look are the groups that have the most experience in terms of dealing with multiple chronic conditions, and particularly with the behavioral health, because so often in Medicaid, you get carve-outs of these areas, which makes everything more complicated. So you want to look at the models where you have that they're included, not excluded and carved out, to see both in terms of the measurements they're using, but also some of the best practices in terms of how to get there.

CHAIR ROWLAND: Patty?

COMMISSIONER GABOW: First let me apologize for arriving late. Planes don't always come when you want them to.

I have a comment and a question, or maybe they're both questions, but the first is about best practice. We know that in the medical field, understanding what is the right way to do something that is

evidence-based takes about 17 years to get adopted. So what do you see as a pathway, when you talk about sharing best practices, that actually get them used, sort of mandated -- short of mandated, that someone decides this is a best practice and then all of you are going to have to march in that direction?

And my second comment relates to that. You have so much experience in this area and it's pretty clear that the solutions, some of them at least, are known. But trying to get them implemented in a program that has 50 states and the states have 100 legislatures or more who have differing views, is there any path that's clear to you by which 50 states can move in a direction which actually will be the best direction to create high quality and low cost?

DR. WILENSKY: It is going to be very difficult to get uniformity in terms of how you get there with 50 states. I mean, I think that's clear. I think the question about whether that's necessarily what we want, uniformity there, is a slightly harder question.

What we want is a focus on the clinical outcomes that people are experiencing with some attention paid to process when it comes to certain practices, immunizations, other practices, where there's enough indication that for those areas, looking at if the practice is adequate instead of looking only at various adjusted mortality or morbidity outcome measurements combined with patient satisfaction kind of measurements.

We do things differently in different parts of the country, and I think we're not going to get a uniformity in terms of a best practice of necessarily exactly how to produce a particular outcome. But to the extent we have -- I mean, unless there is just clear, overwhelming evidence which there is in some areas, that clinically there is one or two appropriate clinical paths and there are a lot of other paths that are considerably less desirable, the focus needs to be on the outcomes measures that you're achieving, and both a public reporting and a payment that focuses on that, and then sharing of a best practice information, because then you have a motivation that is really quite different.

If it makes a difference as to what you do in terms of improving clinical outcomes because of your payment, which is far easier to do in a managed environment, in a capitated environment than it is when you're doing a fee-for-service where it's very hard to do much to the payment, or even like a DRG payment where it's very hard to do.

Then you have a lot more motivation as to what you have to do in order to try to get those good outcomes, which may be slightly different in different places because of the mix of people that they have available in terms of the health care kind of professionals that they have available, and that will also make some difference in terms of the ancillary services that they're going to want to use.

But you really need to get a very different orientation than what we've been able to do in terms of payment. And it's why, unless we move away from what has been this a la carte fee-for-service payment, which completely dominates physician services in Medicare and completely dominates the duals in terms of Medicaid, you're chasing the wrong area and you're going to have fights that you don't need to have fights with, which is my way not your way.

Now, the good news is that we've gotten a little better in the 17 years that it used to take for implementation. We're not much better, but there are areas where we've had enough change that they've stopped being used as measures of good quality care because the numbers have gotten so high.

The notion about why it sometimes takes that dissemination so long has long been perplexing. If there are -- I mean, I think it's going to involve a lot more leadership in the medical professions than we have sometimes seen in terms of aggressively changing some of the activities.

Getting the under 90 minutes for PCI has been something that has been able to change many institutions in terms of how they were treating their patients and better allocations as to who is doing what in terms of cardiology and how to do the mix and match between who needs to have services immediately there and how to best move patients.

So we have some indications when there's either widespread agreement about the process associated that is linked to a good outcome, which is how long does it take you once you hit the door to actually be treated, or very clear outcome measures.

You can drive change -- and it is clearly much more than just payment change. Now, again for me, it's why would you not want to have payment incentivizing in the same direction. But it is also clear that public reporting goes a long way and that institutions, physicians, groups, want very much to be in the top of their area and will go to great lengths to try to do that.

So I think it is really trying to -- be sure you're focusing on the levers that you really want. That is the way to try to get the movement. Now, it's all much more complicated in Medicaid because frequently the payments are just so low. I mean, it's much harder to reward when you've had years and years of pushing down payments. That's sort of the bad news.

The good news is, there's nothing little about the money that's being spent in duals. I mean, there is a ton of money that is out there. So it is hard to do it in the moms and kids acute care area because the capitated amounts are really low. But that's not where the big problem is.

So it's almost analogous to -- and I probably offend people from Florida every time I say this, but if you can't make money in managed care in Florida, there's something wrong. I mean, the payment rates are so high that you've got to be finding a different business.

Well, if you can't figure out how to do it better with the duals, you ought to hang it up and move on to something else. There is just so much money that is being spent. We have got to be able to do it better. So it's very hard in the acute care world to do this because the states have squeezed so hard, I don't know there's a lot. But fortunately, that's not where the problem is.

COMMISSIONER RILEY: I do have a question. Assume a miracle has occurred and we've found a way for Medicare and Medicaid to share resources in a truly integrated dual eligible demonstration

or initiative. If you have the magic wand, what would be the two or three measures that would be critical to measure value and quality in a dual eligible initiative? What's the most important things we need to achieve?

DR. WILENSKY: Well, you're clearly going to have to look at the clinical outcome in terms of what are going to be single and multiple chronic diseases. So looking at diabetes and hypertension and congestive heart failure and looking at both the clinical outcomes associated with that and the re-admissions or preventable admissions that occurs would be -- I mean, those would be places that I would start, the ping-ponging between the hospital and the nursing home.

And again, it has to be in both the nursing home and the hospital's interest to cut that out. So you need to find a structure and then you need to be able to look at the preventable admissions and re-admissions in both places.

It is very disruptive for an older patient to go back and forth and it is frequently not necessary, but there has to not only be the support structure, usually in the long-term care facility to be sure they're treated appropriately, but there has to be a financial incentive on both parts to make that happen.

So if you look -- that's where I would focus is, looking -- I mean, those are the major areas of the five chronic diseases, diabetes, congestive heart failure, hypertension. I've got three out of the five and not sure what the other two are. But looking when you have -- and then looking at the preventable re-admissions and looking at some of the unexpected weight gains.

But they'll be within those particular conditions, a couple of key markers. And then you have to use some of the CAHPS measures. You have to look at a few of the consumer attitude and satisfaction measures.

CHAIR ROWLAND: Gail, we appreciate your insights and your magic wand and you have given us a great deal to think about and a great deal to help us guide our work in the future. We will certainly

love to have you back. We appreciate your comment that MedPAC should work with us because we think MedPAC should, so we will try and see what kind of a joint venture we can get there and maybe we'll be the first attempt at integrating Medicare and Medicaid on the ground for the dual eligibles. So thank you very much.

DR. WILENSKY: Thank you for having me and now you'll get to hear from some of the people who are much closer to where the rubber meets the road.

CHAIR ROWLAND: We are going to have April. Gail is always a hard act to follow, but we have April Grady on our MACPAC staff here to really look at talking us through some of the key issues in the analysis she and the staff have been working on on Medicaid spending as a context for our value and quality discussions, so I am going to ask April to kick off the discussion.

MEDICAID SPENDING: CONTEXT FOR VALUE AND QUALITY DISCUSSIONS

* MS. GRADY: I will just say for the record, I did beg to go before Gail so that I would not have to follow her, but this is the order we have.

As Diane mentioned, I am going to talk to you today about information on Medicaid and CHIP spending because it does provide relevant context for the discussions of paying for quality and performance that you are having here today.

As you know, Gail just talked to you about value, and the session following me is going to be on linking payment to quality. So this is just going to provide you some information to have in mind as you think about those things.

A lot of what I'm going to do today is a refresher on what the Commission has included already in its March and June reports this year to set the stage for where we might be going over the next year.

As you know, today, Medicaid and CHIP account for more than 15 percent of U.S. health care spending and a sizeable share of Federal outlays, State budgets, GDP, so the message is Medicaid and CHIP

are big. Spending growth has been driven -- I say that jokingly, but --

CHAIR ROWLAND: You are following Gail. We are following the money.

[Laughter.]

CHAIR ROWLAND: Exactly.

MS. GRADY: Spending growth has been driven by different factors over the years, and we will talk a little bit about that. Some of it is enrollment. Some of it is spending per beneficiary. And we will talk about the fact that you can measure growth in a number of ways. You can look at growth in aggregate spending. You can look at growth in spending per person.

And then the other thing I will talk about is the fact that aggregate statistics on Medicaid spending can mask wide variation across States, and we all know this is a State program. Part of what we try to do with MACStats is to make sure that we present State-level information to show that variation.

Okay. So on the topic of Medicaid and CHIP are big, the Commission's March and June reports provided a lot of information on Medicaid and CHIP spending from a number of different angles. As I said earlier, more than 15 percent of U.S. health care spending in 2009 went to Medicaid and CHIP. But just to provide a little context, Medicare and other public programs accounted for about a third of total U.S. health care spending. So Medicaid and CHIP are big, but so are Medicare and other public programs. Medicaid and CHIP accounted for about eight percent of Federal outlays in fiscal year 2010. As a point of reference, Medicare was about 12 percent.

We also showed in our March report that Medicaid is about 12 percent of State-funded budgets. Now, this is lower than the typical number that you might see out there, and again, this is reflective of the amount that States have to contribute from their own general funds and other non-Federal sources of spending. And as you know, State budgets are made up of both Federal and non-federal sources, and here, when you limit the analysis to that non-Federal portion, which is the part that States have to finance on their

own with taxes, Medicaid is about 12 percent of that State-funded budget.

VICE CHAIR SUNDWALL: April, I just can't help but interrupt you there, just because a frequently-cited figure I have heard is 20 percent.

MS. GRADY: And that is when you include both the Federal and the State spending. So if you look at the State budget as a whole, money is coming in from the Federal Government. Money is coming in from income and sales taxes and other State revenues. And so when you look at that big budget as a whole, Medicaid, including the Federal funds, is about 20 percent, on average. But when you limit the State budget to the State-funded portion, excluding the Federal revenues that are coming in, the part that the State has to raise on its own, when you look at it in that context, Medicaid is about 12 percent, on average. And compared to the next biggest item in the budget, which is generally education, elementary and secondary education are about a quarter of State-funded budgets. So there's a relative size issue there. Again, it really depends. You have to be specific about what portion of the State budget you are looking at.

One of the other things that we talked about in our March and June reports, Medicaid and CHIP are a little under three percent of the Gross Domestic Product, so it's a big part of the U.S. economy, not just U.S. health care spending.

And then one other point to make that you have heard over and over again, Gail talked about the portion of enrollee -- a small portion of enrollees account for a large portion of spending, and she talked about the aged and disabled in particular. Here, I gave an example where we in our June 2011 report have broken out users of long-term services and supports, most of whom are aged and disabled, but those folks are about 23 percent of enrollees and about 62 percent of Medicaid spending in fiscal 2008.

The next slide here is just an example from our June report about the kind of break-out that we were doing.

The next thing I want to talk a little about is the factors that are driving Medicaid spending growth, and in our June 2011 report, we talked about these factors and gave an example over the period 1975 to 2008. When you look at real Medicaid spending growth, meaning the amount above and beyond inflation, the real increase in spending that occurred, about two-thirds of that growth in that Medicaid spending during that time period was because there were a growing number of people coming on the program, from population increases, from eligibility expansions, and a particular driving factor here was an increase in the number of people with disabilities. Now, in absolute numbers, that wasn't a huge growth. There's still a relatively small number of people with disabilities. But every time one disabled person comes on the rolls, that person's enrollment has a disproportionate effect on spending because they are so expensive.

The remaining growth in Medicaid spending was due to increases in spending per beneficiary, and that can reflect a number of factors, for example, changes in the breadth of benefit packages over the years.

And one thing I want to point out, of course, these percentages in terms of the amount of spending growth that was due to increase as enrollment versus spending per beneficiary, they're very sensitive to the time period that you look at. And so we happened to use 1975 to 2008 here to examine factors that have been driving growth in the program over the long history. But if you focus on a particular time period, you'd find recently, for example, recent growth during the recession -- this is in the early 2000s -- and in the current downturn, a lot of that growth is probably driven by enrollment. So, again, this is going to be sensitive to the time period that you examine.

We all know that 2014 is coming and there will be a big increase in Medicaid eligibility in that year. So CMS recently updated its National Health Expenditure projections and what they are projecting is that in 2014, Medicaid spending is projected to grow about 20 percent in that year. So that's a big one-time jump because of the increased enrollment from eligibility increases.

After 2014, CMS is projecting that Medicaid is going to grow at an average rate of about 7.5 percent

through 2020. And just as a point of reference, from the late 1990s to this year, growth in total spending for Medicaid ranged from about five percent to 12 percent, depending on the year that you are looking at, and it was an average of about eight percent. So the growth after 2014 isn't much different than what we've seen in recent years. It's that sort of one-time jump that is relatively unusual.

And by 2020, because of this increase, CMS is projecting that Medicaid is going to pay for about 20 percent of U.S. health care spending in 2020 as opposed to the 15 that it does right now.

So the next thing I want to talk about is the fact that a lot of these statistics that we throw out are aggregate national information and Medicaid is a State-level program, so these statistics kind of blur the variation that exists across States.

So even when you try to limit your comparisons to similar populations, which is what you need to do to get an apples-to-apples comparison across States, you still find that spending per enrollee varies substantially across States. So something is different, you know, even when you look at the same enrollees in one place versus another. And there's some recent work indicating that a lot of the variation, at least in terms of acute care services, is due to differences in the amount of services that people are getting rather than price differences in New York State versus California or Arkansas. So a lot of this, we don't have specifics about why the volume varies, but there could be a number of reasons for that.

Some of this work has also found that there's much more variation in long-term care services than in acute-care services. And then within acute care itself, mental health care is one component that is particularly variable across States, and this sort of ties into what Gail had been talking about earlier, about the importance of focusing on this issue since it is one where spending does vary considerably across States.

And then one sort of -- this seems like a wonky issue to cover again and again, but really, driving home the point that it is hard to make apples-to-apples comparisons of Medicaid spending across States for a number of reasons that we've talked about here in Commission meetings, and one is the quality and the

completeness of the data that are reported, and we talked a lot about that in our March report to Congress.

Another issue that makes comparisons difficult is the extent to which States are making supplemental payments that are not tied to service use by individual enrollees. So that is clearly part of the total Medicaid spending picture, but it's very hard to attribute those supplemental payments to individual enrollees, and so when you start doing calculations of per person spending, you really need to take that into account, and our June 2011 report discussed this issue in depth and talked about the methods that MACPAC has used to ensure that the data that we're publishing at a State level account for these factors.

But even after you make adjustments to account for these data and these supplemental payment issues, you still have a comparability problem because States have different mixes of enrollees and benefit packages that drive their spending levels. So the research that I just noted tried to control for that, again, by looking at differences across a similar enrollee population, limiting it to comparable people. So even when you limit it to comparable people, you still see a lot of variation.

So I'm not going to read these potential discussion issues aloud because you may have other ideas, given what you've already discussed today with Gail and what might be covered in other sessions at this September meeting. The purpose of my presentation today was to provide context for these discussions and to get your feedback on potential issues for MACPAC staff to pursue in greater depth with regard to spending or any of the topics that have been raised. So I'll leave it at that and welcome any questions that you have.

CHAIR ROWLAND: Thank you. Patty.

COMMISSIONER GABOW: When you try to look at this variation across States in terms of cost, one variable may be the provider delivery system that is in. You have looked at -- and maybe Sharon has the answer to this -- the cost per Medicaid enrollee across FQHCs across States, because you could look at comparable patient populations, like adults with chronic disease and women and children, and since you

use supposedly cost-based reimbursement, it might be illuminating about whether there's variation within a State and in FQHC, whether the variation is greater across States. I think that gets rid of one important variable, which is the delivery mechanism. But I don't know -- I haven't seen that data, but maybe someone knows it.

COMMISSIONER ROSENBAUM: I mean, if you look at both rural health clinics and Federally Qualified Health Centers, you see the same thing, which is that provider-based entities, ones that are affiliated in some way with an institutional provider, are much more costly. They carry a lot more of the costs. Freestanding entities are less expensive. Entities that have a public link are more expensive. And so you can definitely appreciate within any one State the differences for the same rough market basket of procedures, the same patient population. But that would also be true, I would think, for hospital outpatient or hospital inpatient or anything where you're matching benefit class or service class by service class.

What I'm also curious about is whether the States that show high cost patterns generally show high Medicaid cost patterns, you know. So does Florida show very high Medicaid spending, just like it shows high Medicare spending, or does one follow -- does night follow day here or are they different?

MS. GRADY: I don't think there's been a lot of research on that. I think there has been some work looking at comparing Medicare and Medicaid costs at the State level, and I don't have that research right in front of me, but I do recall seeing that there's much more variation on the Medicaid side. So that's not unusual given that the benefit package, in addition to the sort of input prices, could vary.

Now, even when you do limit it to similar services, though, what the research has found is that there is greater variation in Medicaid versus Medicare, but we have not -- we haven't gone down to that State level and that's the sort of feedback we're looking from you about, you know, Commissioner interest in examining those things.

CHAIR ROWLAND: And, April, perhaps one of the better comparison points might be to look at children across because they've got a much more uniform benefit package and there are payment rates and other things which really influence it.

Steve first.

COMMISSIONER WALDREN: Yes. There is also one, and I can go back and find it, but a Dartmouth study looking at that, because they were looking at variation and what they found was that the biggest variation was not really about price, but it was really about those things that we do not have good evidence for.

So, for example, we have good evidence about diabetics, and you probably should be seeing them every three months or so, and we could have a clinical argument if that is right or not. But there is kind of kind of agreed upon. But the question becomes somebody that has hypertension that doesn't have comorbidities and doing well. Do you see them once a year? Do you see them every couple of years? Do you see them once a month? And what they have found is those things that there wasn't good evidence or best practice had the greatest variability and drove a lot of the cost. Now, they didn't look at Medicaid specifically, but I don't remember if it was Medicare dollars or if it was local claims they had up in Dartmouth.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: Since I think we are particularly interested in the so-called high-cost population groups, both duals and other groups, I'm wondering -- you were talking about some research that didn't explain, and I guess we've also just been talking about research that didn't explain the differences in per enrollee costs, and I wonder the extent to which that research that you were speaking of deals with high-cost populations or if that was a more general population. And I guess I'm just asking, what do we know about the high-cost populations in isolation from other Medicaid groups?

MS. GRADY: So the research that I was speaking of did look at a particularly high-cost population. It was non-dual eligible SSI enrollees, and so the reason that the researchers chose that population is because there are uniform eligibility rules for that population and so they wanted to get the most comparable group of folks they could across States.

And so there, with this high-cost population, again, you did see a lot of variation, again, much more on the long-term care side than the acute care side. So if we're talking about the Medicaid spend, that's where there does seem to be a lot of differences across States and that may be driven by the benefit package differences, by the way those long-term care services are delivered. That's the part where sort of the next step hasn't been taken.

COMMISSIONER MOORE: That suggests you really need a case study to -- along with that kind -- I mean, you have to go another step, really.

MS. GRADY: I think what it certainly suggests is that you have to have qualitative information, qualitative context for looking at these numbers. It's not enough to say, you know, oh, here's this variation. You have to understand the benefits that are being provided, the extent to which managed care is being used in that State. So I think it means a lot more work for us as a Commission to understand what's going on in those States in terms of the delivery systems. It's not just payment rates. I think it's also the benefit package, how the services are being delivered.

COMMISSIONER COHEN: For dual eligibles in particular, I would -- wondering if we have done this, and if we haven't would suggest that we should. To the extent that there's significant variation in utilization of certain kinds of services, like long-term care services or something, I mean, one thing that we really lack is really an understanding of whether -- where the right answer is, like whether -- obviously, it's cheaper to provide less -- it's cheaper, long-term care services, to provide less long-term care, but it may be that if you look at the total services that somebody receives, that more long-term care services would be

better. So can we look at Medicaid utilization in certain categories along with Medicare utilization for those same people so that we can see whether more use of certain Medicaid services might result in less use of certain Medicare services, but to always look at the whole picture of services to help us assess whether maybe the right answer for certain services is more. I mean, we know that in some areas, that that's the case.

MS. GRADY: So we have not done that work yet, but that is one thing that we're actively doing right now, is working with -- for dual eligibles, in particular -- data that shows their Medicare spend as well as their Medicaid spend and looking at the total picture. So MedPAC came and talked to us last year about the work that they had done on that issue, looking at the merged Medicare and Medicaid data for duals, and we're going to be undertaking a similar exercise but going down to the State level, again, because looking at that variation really -- it's difficult to do at a national level, so we need to get down to that State level. So that's what we'll be doing, focusing on over the next several months.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: I sympathize with you, trying to do the State-by-State comparisons. Mercer has tried to do that for a long time without much success.

A couple other thoughts we've had or things we've done, and it doesn't solve the problem but sometimes it puts Medicaid in a better light if you can get any data on what commercial coverage is doing. Sometimes, the private sector is brought up as a higher standard or they're way better at this than State staff are and they have more tools at their disposal. They have cost sharing levers that we can't use, these wellness programs or just better technology, consumer-directed health care. But a lot of times we've found the Medicaid costs per beneficiary, per person, run below what they are in the commercial sector.

Or another thing that we've looked at that's sometimes closer to home when our clients, people from DPW or DHS or whoever is running Medicaid, are getting beaten around the head and shoulders is to

compare to the State employee plans, another huge group of people all covered under the same benefit program, all administered frequently by managed care, sometimes the same plans. There, too, we have seen State employee plans run rates of increase or inflation that are double, triple what Medicaid is running. So it doesn't really help you lower the Medicaid cost, but it provides some more context for what is going on.

MS. GRADY: And I think that's definitely part of what we've tried to do in our March and June reports, is always to provide that point of reference, and I think that's something we can do going forward, and I think MedPAC, and talking about coordinating and piggybacking on analyses that they have done, I know at one of their meetings last year, they had been looking at commercial payment rates, physician payment rates compared to Medicare, and so we might be able to sort of see what they have done on that issue in particular.

CHAIR ROWLAND: Richard.

COMMISSIONER CHAMBERS: Yes. I just wanted to make two comments. One was the one on looking at FQHC or look-alike costs, and I can tell you, just within our county, we've got about a dozen FQHCs and look-alikes and the PPS rate, the encounter rate, ranges from, like $80 to about $220, and the hospital-affiliated one is the one at the top end, which explains that. But that variability within the same geographic county doesn't seem to say it's cost-based. How could the cost be so different? But just a comment.

The other thing is when you look, I think, at State-by-State variability, even looking in a big State like California, is the variability within a State, because Northern California is much more expensive than Southern California, the delivery of health care services, and it bears out with what the State pays plans in Northern and Southern California. But I think it goes back to what is the cost of delivering the health care, and in an area like Southern California, which is a very heavily managed care delivery system, both in

commercial and senior and Medicaid, the cost of delivering care is so much less because it's a very competitive marketplace.

You know, we always complain about looking at New York and the per member per month expenditures in New York versus California. What doesn't make sense is to pay more if you're getting access and quality at a lower cost. Is it wrong that California is buying it cheaper in Southern California? Do we as a Commission say, that is the wrong amount of money? Well, it is the right amount of money for the local delivery system, so I think it's really hard to judge this, just an absolute number is right or wrong. I think it is what you are getting for that. And it gets back to the value purchasing, is what are you getting for the dollar as opposed to what you are actually paying.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I wanted to take us back to the growth in the Medicaid program. We always quickly dismiss that it's largely enrollment, but the real issue is it's largely enrollment of people with disabilities. So it's the "who," and those people are disproportionately expensive. As we move toward thinking about managed care for those populations, we can't take that step, it seems to me, until MACPAC takes a little harder look at the benefit package.

What we don't know about people's disabilities, be it MRDD, behavioral health, physical disability, is much about what the benefit package really looks like. We get the big chart with the checkmarks, but it doesn't tell you what the benefit really is, and I don't think you could do that State by State by State, but it might be valuable to take three, four populations of people with disabilities and look at a number of States and look at what their package looks like, because I think, otherwise, if we don't get a better handle on how rich or thin these benefits are or what they are and what they achieve, when you think about a managed care plan capitating all this swirling money, there's room for mischief that we won't be able to manage.

So it seems to me it's a value added to the field to really get a handle on what those benefits really

are and the benefit limits, and, you know, you can have two visits of that and five visits of this, you know, what achieves better outcomes for these populations, before we move into managed care.

COMMISSIONER ROSENBAUM: Going back, actually, to Patty's point and Richard's point, I think it would be interesting, actually, to take the FQHC payment as sort of an archetype because it's such a big source of primary care. Of course, they're dominant providers in managed care arrangements plus fee-for-service providers. And my guess is that it would be very illuminating to people, because what would begin to show up is that, of course, affiliation matters. The market basket of services offered matters. I mean, you really can get a pretty broad array. You can get FQHCs with big pharmacies, with whole dental programs, with behavioral health under one roof. I mean, they really are -- I think you said it before, Denise, like ACOs under a roof. You know, they have everything going on except specialty care, and so you would expect their costs to be higher per encounter.

And then you have others that are much smaller, staffed at a lower level, fewer capabilities in-house, and be able to get down to sort of gradients of FQHC services so that you can begin to compare even their apples to apples. You know, what makes a nurse practice managed FQHC in a rural area in one State more costly than one that looks a lot like that in another State?

Also, I think the demographics of the patient population. So if you have, you know, if it's an area with a lot of older residents, you'll get one profile. If it's mostly younger people with a smaller proportion of elderly patients, you're going to get a different profile.

But I think that this idea of sort of taking archetypal things in Medicaid, whether it's a population group, whether it's a specific provider that is well -- that is commonly thought of in the context of Medicaid, and shining a light on the issues and the challenges so that, you know, just capping the payments isn't an answer or cutting back on the benefits isn't an answer, that we have to think much more about what do we want to encourage. I mean, do we want to encourage FQHCs to be more complex and take sicker

patients? Do we want to encourage them to be affiliated with a provider? What do we want to encourage? And depending on what we want to encourage, you are going to get a higher cost or lower cost FQHC.

We could do the same thing around nursing homes. We could do the same thing around a lot of providers. But I think a great service of MACPAC would be to get down below the surface of the program with a few services that really matter.

CHAIR ROWLAND: You know, April, as you go forward and as the staff goes forward, I think it would be very helpful to give us some feedback on what you can learn from the existing databases, how out of date many of them are. But I think what I'm hearing from the Commission members is we may need to go out and do some direct data collection, whether it's on a selective case study basis or whatever, to be able to get inside the box of what's going on here.

Mark, and then we will have to wrap this session up.

COMMISSIONER HOYT: Maybe a couple other thoughts real quick on long-term care that would be the questions we ask when we go into a State. How many waivers do they have that touch some aspect of long-term care? And when I say that, I mean MRDD plus elderly physically disabled, the point being sometimes you will see ten, 15, 25 waivers that hit different aspects of that. It could be an indicator of inefficiencies because there are so many just separate little pieces. Percentage of, let's just say the two populations, MRDD and the elderly physically disabled, what percentage of them are in home and community-based services? A lot of variation there between the States. And then, I haven't looked at this for a while, but if there are some slivers of service or breakdown in costs like around personal care attendants or something else that would be close to the same to same across States, you could look at that, too. I've seen huge variations in that.

There, too, the things that frustrate me like crazy is I've been in one State where sort of the glass is

half-empty or sort of half-full, where their personal care attendant cost was just sky high, and I asked them about it and they said, well, it employs a lot of people and, you know, we're only paying half the cost or whatever it was. So it doesn't bother us that much. Okay. You're, like, way out of bounds compared to this State and that State, but it didn't bother them. That was a while ago.

CHAIR ROWLAND: Well, with that, thank you very much, April and staff, for this presentation.

We're going to take a seven-minute break and then come back to continue to talk about more on the ground perspective of quality Medicare and Medicaid. Thank you.

[Recess.]

CHAIR ROWLAND: Let us reconvene, please. I know breaks are always fun, but it's time to get back to work.

We have begun our discussion of payments and quality, but this Session 4 is going to really look at linking payment to quality in Medicaid. I'm very pleased that Margaret O'Kane, the President of the National Committee for Quality Assurance, and Jeff Schiff, the Medical Director for the State of Minnesota Public Programs are both with us today to give us an overview as well as some on-the-ground state experience. I'm going to ask Jennifer Tracey on the Commission staff to start us in this discussion and open it up. Thank you, Jennifer.

LINKING PAYMENT TO QUALITY IN MEDICAID

* MS. TRACEY: Thanks, Diane. As we discussed this morning, one of MACPAC's key priority areas for the 2011-2012 reporting cycle is examining quality, and specifically its role in determining value in Medicaid.

In thinking ahead to proposed analytic work for this upcoming cycle, some of the potential projects that we're considering is an examination of Federal quality requirements and also, as we've discussed, an exploration into state efforts to monitor quality and link payment to provider quality efforts.

Recently there has been quite a bit of interest at the Federal and state levels about what the quality landscape looks like currently and how best to measure quality for Medicaid beneficiaries. And more specifically, what are the best measures to use for these populations? What are the innovative approaches that states are using now? And what successful efforts are out there that really link payment to quality?

As we've heard throughout the morning and the afternoon, quality measurement and monitoring improvement efforts have been receiving increased attention, and this is due in part to increased technology that's available to collect and analyze quality data as well as the development of a variety of measures that can address quite a few health outcomes.

Payers have also shown an increased interest in using population-based quality measures, and states are increasingly using tools such as HEDIS, CAHPS, and pay-for-performance to drive quality improvement. In addition, states are also implementing programs such as medical homes and exploring accountable care organizations as ways to further improve quality through coordinated care efforts.

At the Federal level, states must meet certain Federal quality requirements. However, there is quite a bit of flexibility in the tools that states use, and also the information that's reported back to the Federal Government. Also at the Federal level, the patient protection and Affordable Care Act established the Center for Medicare and Medicaid Innovation. This center is tasked with testing innovative payment and service delivery models that strive to enhance and preserve quality of care.

The Act also included some hospital payment provisions, including some upcoming bundled payment demonstration projects that are set to evaluate the integration of care for Medicaid beneficiaries, and also the establishment of accountable care organizations for certain eligible pediatric providers.

As we've heard a little bit and we'll learn more in this next panel, little is known as to what extent states are currently linking payment to quality, and really the outcomes of these efforts. And part of this is a lack of resources at the state level to crunch a lot of this data, and also the fact that a lot of these efforts

are still in their infancy and the data isn't readily available.

So today we'll be hearing from the National Committee for Quality Assurance on challenges of measuring and assuring quality of Medicaid, and also learn more about some of the quality improvement tools that are available to states, and also some quantifiable outcomes that are coming out of select states.

And finally, we'll hear from Minnesota about their experience using payment incentives and some lessons learned that other states can use in trying to link payment and quality. Okay.

MS. O'KANE: Thank you.

MS. TRACEY: And I'd like to introduce Peggy O'Kane from NCQA.

MS. O'KANE: Yeah, call me Peggy. I'm told that –

CHAIR ROWLAND: There's an additional handout that goes at Page 7 of your chart pack that was passed out earlier today to just replace a chart there. Thanks, Peggy.

* MS. O'KANE: Thanks. I really appreciate the invitation to be here today, and we really look forward to the dialogue with you. I was here for Gail Wilensky's presentation, too, and I think I really agree with her about many of the things she said, but I would like to pick up on some of those conversations.

So I think NCQA has been working on many different approaches to improving quality. HEDIS, for all its limitations which we're all aware of, I think, really has done a lot to advance the quality of care, and I'll talk a little more about that.

Patients that are in medical homes, I think we're very excited about what we see about their potential to really transform the delivery system, but also to be used as kind of the nexus for a broader transformation. So I'll talk about in a little bit.

Accountable care organizations, I think I agree with Gail's guarded view about how many of these we're going to have and how much they're going to be the answer. But I think ultimately, this is kind of

the construct that we want because you want something that's big enough to accept accountability on a broad scale for coordinated care and for being efficient.

I don't know how many of you have had a chance to visit Patty's Denver Health, but when you see what people actually do when they're trying to be efficient and trying to get lean, you understand that it's so much the opposite of what goes in our system today.

Multi-cultural health care distinction. We have a program that's kind of a special distinction for plans, and I'll talk a little bit about that. And then pay-for-performance, which I do believe has yielded some positive results and we need to be much more strategic about it, I think.

So HEDIS, we currently have half the states that require Medicaid plan reporting, and I have to say I've been the head of NCQA for 21 years and we've been chasing Medicaid continuously, and sometimes it feels like we're on a treadmill, because I think that there's always this desire to believe that things are different in my state, and indeed, they are different in every state.

But I think we're very proud of the progress that can be made when you have the ability to benchmark and really reward high performance. I think -- I don't want to get into a discussion about quality, but that slide with all the problems I'd like to talk about in the discussion.

Our results are rigorously audited and scored, and that's really, really important. We learned that early on when we started collecting HEDIS data. And we are continuously updating the measures and we now actually, because we think value also is such a central concern no matter who the payer is, we've been approaching cost and quality.

And I think one of the things that I've always felt is, when I went to graduate school, we had to think about the trade off between cost and quality, and I think we're past that discussion these days, and that's actually a very good thing.

The challenges of measurement for Medicaid are legion. Some of the most important ones are --

well, one really goes to the spottiness of our evidence base in medicine. We're often, in many areas of care, where we're not really sure what works and that leads to limitations in measurement.

We have a philosophy which we try to adhere to, that we try not to measure things that are really controversial or, you know, not sure how much benefit we get for them, because by the very act of measuring, you're driving use. So sometimes there are things that are not covered in measurement for that reason.

We have a lot of churning in the Medicaid population; you know that. And that leads to smaller parts of the population being covered by measurement, which leads to holes in accountability which are very unsatisfying. Social determinants. You know, I think there's a lot of debate, I think, in the larger health care system about whether we ought to be adjusting performance for people with special challenges because of their socioeconomic status and so forth.

We don't believe we should adjust away things that need to be dealt with, but we have to admit that this is a very important issue and that trying to focus on health care to the exclusion of these social factors can sometimes lead to crazy results, and especially when we talk about the disabled or the frail elderly. I think these issues become more and more paramount.

State variation in reporting specification. This is what I was talking about with chasing HEDIS. Chasing states with HEDIS, trying to keep people on the same platform, and the desire to tweak, and we call it SCHMEDIS, actually, once it's been tweaked. It's just so irresistible and so we're constantly having to go make our pitch, please use our measures because we want more and more of the population covered.

And then I think the inability to make comparisons with fee-for-service is very unsatisfactory. And personally, I think there are some possibilities. I mean, many of the states are using primary care case management programs where there is actually a population and you could compare, and I think we would very much love to work on a project like that.

But I think in general, in fee-for-service, the fact that it's so atomized leads to -- you can measure down at the atomic level, but it actually doesn't add up to anything coherent, and that's really the most important point.

You know, we can drive ourselves crazy trying to measure individual practitioners, but at the end of the day, even if you have seven, for example, individual practitioners seeing the same patient and they're all adhering to their own standards of quality, that does not add up to patient-centered quality.

When you put it together, there are going to be contradictions, overlaps, redundancies, you know, all kinds of gaps in care. So this unit of measurement issue is very much central to the whole accountability agenda. And I think we'll get there.

We're proud that results have gone up over the years. One of our kind of shocking findings last year was that after years of improvement, childhood immunization rates had gone down in the commercially-insured population, we think because of the all the buzz about autism and so forth. It doesn't seem to have had the same impact on Medicaid populations.

Chlamydia. Actually, Medicaid plans, as you can see, outperform commercial plans on this, and by a very healthy margin. I think people are surprised when they see that. We have some measures of inappropriate care. You know, there's kind of a shortage of clarity about what's inappropriate in medicine that really holds us all back.

But this is one of the areas where I think there is consensus that premature imaging for low back pain leads to procedures which are often ineffective, and the best predictor of having back surgery is you had it last year. So premature image in back pain is actually a dangerous situation for patients.

We have avoiding antibiotics for acute adult bronchitis. You can see this has come down a bit, but it's sort of flattened, and in Medicaid it seems to have kind of plateaued.

One of the areas that we've been looking at is, what does it take a plan to achieve certain quality

measures for a particular population or certain quality levels of performance? So we've put these up here as an example. What we've done is we've taken chronically ill populations, five populations, asthmatics, diabetics, people with heart disease, people with hypertension, and I don't remember what the fifth one is, but this is for people with diabetes.

We've combined the quality measures so we could have kind of an index of quality. You know, we have a number of different measures in the diabetes composite measure. And then we look at the medical inputs and we standardized the price of these things so that what you see on the other columns is actually an index of utilization or an index of inputs.

So in this example, you can see that Plan D is 14 percent higher than the average of all the plans, 1 being the average. And it does that probably with more use of drugs, which in diabetes makes sense. We don't see that pattern in other diseases. But you can see that their combined medical costs are about 26 percent lower than the other plans in the comparison group. And inpatient facility costs are lower and so forth.

So it's a kind of way of really trying to benchmark, and we're publicly reporting this now on plans, benchmark what it takes for people to get to certain levels of performance. And I think for each plan, they need to look at their own inputs to understand where the opportunities lie to do better.

VICE CHAIR SUNDWALL: Peggy?

MS. O'KANE: Yes, please, David.

VICE CHAIR SUNDWALL: Excuse me. Just a clarification on that plan that you're going across. When you talk about combined medical inpatient, are those costs?

MS. O'KANE: Yes, standardized costs.

VICE CHAIR SUNDWALL: Okay.

MS. O'KANE: Yes.

VICE CHAIR SUNDWALL: Thank you.

MS. O'KANE: So we're most interested in measures for special populations. I think that we all understand that while if a person in a special population like a frail elderly person or a person with a disability, has diabetes, they have to be managed for their diabetes, but their needs are so different and more expansive that we need actually a different logic of measurement for these populations.

We feel that there are many opportunities to do much better with these populations. I know with my own mother, I witnessed what this was like at the end of her life, and there were just multiple, multiple opportunities. I've played case manager, actually, as many of you probably have with your own parents, and the opportunities for improvement are legion.

So we are very pleased that we've just completed Phase 1 of a project for the SCAN Foundation to set measurement priorities for the dual eligible populations. And this is a challenge that's much bigger than anything we've ever faced in the measurement work that we do, and the measurement work that we do is not easy, I must add.

But all the points that were made already about the different sub-populations, but we had -- first of all, we had a meeting with consumer advocates because we think it's really important to bring them along as we try to move towards more managed care. I think the feeling of threat is out there and I think with some reason.

We then had an expert panel in July and met with the Federal Coordinated Health Care Office in August, and where we're headed, and we're just putting in the proposal for a Stage 2 of this, is -- you know, the patient center medical home, as Trish was pointing out before, is actually a different paradigm for quality. Right?

It's a model of care paradigm, if you will, and it really says, You shall do these things if you are a patient center medical home. We think there's an aspect of quality measurement for these populations that

is like that, you know. You should have a care plan, for example, and then people need to follow the care plan.

You need to have coordinated service delivery. You need to have comprehensive needs assessment, but you also need to look at whatever quality measures are applicable for the medical side, and then we're really hoping that we can work on outcomes assessment for these people. We think that is, obviously, the end game.

I don't want to minimize the difficulty of that because as you know, I mean, asking people how they're doing when they're disabled or they may be demented or whatever the issues are. It gets into all kinds of questions about who do you go to if you can't ask them, et cetera.

So we come at this, I think, with great humility and yet a great sense that we can get a lot further than we are today and that we need to, especially if we're going to start putting people into accountable entities where they're also accountable for the cost of care.

So on the duals measures, as I said, we're just putting in the Stage 2 proposal, which is a larger effort. We're going to be identifying states and models to evaluate the feasibility of measurement, have draft standards. When we're talking about model of care, we call them standards and measures. Test them in three to five organizations, if we get funded. My staff would want me to say that.

And meanwhile, we're also working on a couple of other projects that I think feed into this. We're working on schizophrenia measures with ASPE via Mathematica. We're a subcontractor with that. And inpatient psychiatric measures with Mathematica.

If you look at the HEDIS measures, they're fine for a commercially-insured population. I mean, they're fine, they're okay, you know. They will be better in the future, I have no doubt, as we get electronic medical records and so forth.

But for these special populations, we don't pretend that we think that our current measures actually

are adequate by any means. So we're very, very interested in moving this forward as quickly as possible.

I was asked to talk about NCQA accreditation. We do accredit many Medicaid plans. And you may know, I don't know if you know, our accreditation program has standards and then it has HEDIS measures and then it has CAHPS measures. And HEDIS and CAHPS are now 47 percent of the total score. You know, they're benchmarked against each other and they get points depending on where they come out in these quintals.

And the rest is the compliance with the standards. So we have 25 states where we're working with the states. So 11 states actually require NCQA accreditation, and 14 more -- it can be redeemed, you know. So if you got accredited by us, you meet at least some of the requirements that the state has around quality.

We compare -- of course, we're always trying to understand how do accredited plans do compared to un-accredited plans. And there's a really big spread in the Medicaid sector between accredited plans and un-accredited plans. I won't read you all those results, but I think you can see. These are clinically-meaningful differences in performance.

And there are -- but our penetration into Medicaid, the Medicaid population, is actually much lower than it is in the commercial population. We have 90 percent of commercial. That's HMO lives, I believe. That's not all insured lives. So actually, I'm not sure what I'm saying is actually true.

41 percent -- never mind.

VICE CHAIR SUNDWALL: That's honest.

MS. O'KANE: We have a lot of work to do on Medicaid. That's all I'll say.

VICE CHAIR SUNDWALL: When you say commercial, you're talking HMOs?

MS. O'KANE: Yes. No. Medicaid is mostly HMOs, well, except for the duals which we're not talking about. I don't know. We'll figure that out and we'll get back to you. I apologize for that.

So we're always trying to stay in line with the Federal requirements at least because it's much more valuable to a plan the more that you get deemed. Right? You know, if you get deemed and it only covers 20 percent of what the state is requiring or what the state and the Federal Government are requiring, it's not necessarily so worthwhile.

This brings us up to about 78 percent of the Federal requirements. States like this because it reduces the EQR burden, you know. So it's actually easier for them and they know it's a high standard, and the plans, I think, find it something that's kind of predictable and where they really -- you know, we bend over backwards to make sure that people really understand what we're looking at and what's expected.

Patient center medical homes, as I mentioned, this is -- I have to say, when we started doing this, our board thought we were crazy, and I think we just -- we wanted to do it because we thought it was a really exciting concept and we really had no idea that the thing was going to take off the way it has. So it's just been incredibly exciting.

I make a point of going around and visiting these places and it's just very inspiring to see what people actually do with it. So more than two dozen states have some kind of a demonstration program. HRSA is now supporting FQHC community health center, PCMH transformations, and CMS and HRSA are supporting a Federally-qualified health center transformation project.

We've already processed 525 FQHCs through the medical home and I'm told that most of them got to Level 3, which is our highest level, which is very impressive to me, because these are relatively new projects.

And I think that you've probably seen some of the results. I mean, I think some of them are more scientifically rigorous than others, but there really is good evidence suggesting that per-patient costs do go down, that there is increased access, that there's increased use of evidence-based primary care, and increasing patient satisfaction. Am I over time already? How am I doing? Okay.

And Vermont is another state where we've just been up to understand what they're doing and it's very, very impressive what they're doing, building out from the patient center medical home. As we kind of look at the environment and assume that ACOs are going to be a slow train, we've been more interested in how can you build up to greater integration from the patient center medical home. And, you know, Vermont really has done that.

New York is doing it with their health home project. North Carolina is doing it. So we're actually learning a lot from the environment.

Our Multi-Cultural Health Distinction Program, these are, as I said, optional standards. It's a great program. We have one organization that's come through so far. It's a relatively new program. But one of the points I think we need to all understand is I think we tend to think of these programs as, Well, we have the quality program here and we have the cost reduction program here, and then we have the disparities program here.

But actually, a really good disparities program will lift the quality and it will help reduce the costs if it's done right. So I think we need to think more holistically about this.

VICE CHAIR SUNDWALL: What is CLAS?

MS. O'KANE: Oh, Culturally and Linguistically Appropriate Services.

VICE CHAIR SUNDWALL: Thank you.

MS. O'KANE: Pay for quality. We do see that -- I mean, with all the limitations of pay-for-performance, and I think early attempts are always more naive than what happens as you evolve. Right? I mean, that's just the way things are. It does motivate people.

And I can tell you that the star ratings that Medicare is going to be using, I have never heard -- I mean, some of the organizations that I've talked to recently who really thought quality was something that NCQA was worried about but not them, they have really got this as a priority. If that's what it takes, I

guess that's what it takes.

Anyway, let me just go to the next slide because I'm running out of time. So, you know, most states have some type of pay-for-performance. Some are more sophisticated than others. There's very little rigorous evidence of pay-for-performance impact on quality and cost.

We ran some graphs of performance on overall health plans, and I mean, all our Medicaid plans and then we compared three states. Rhode Island certainly has been on our minds because I think they're the highest performing Medicaid plans in the country and they've been doing this since 1998. It's a very sophisticated program and you can see that their numbers have come up nicely. The red line is lower is better.

Michigan has been doing it since 2001. Again, you can see -- remember the top two lines are showing improvement by going up and the red line by going down. And New York has been doing it, also, since 2000, also. It's more impressive than if you look at the overall results, is my point.

And I think that's it. So I appreciate the opportunity to give my pitch here and look forward to the conversation with you when we're done.

MS. TRACEY: Great. And now we'll hear from Dr. Jeff Schiff from Minnesota.

* DR. SCHIFF: Madam Chair and members of the Committee, it's a pleasure to talk to you. And I'd like to say that there are many states that are tremendous work, and as a Medicaid Medical Director, we got together earlier this week and I'll spend a little bit of time talking about that at the end.

I wanted to just tell you that what I really want to do today is maybe give a little bit of a story of the progression of quality and payment and their interrelationship in one state. And I have to tell you that for this Committee is the only reason that I would be missing part of our visit from our duals demonstration people from CMS who are in our hometown right now, and I was on the phone with them earlier and going back to talk about quality tomorrow.

Anyway, I wanted to just tell you a little bit about Minnesota. Just to set the context, Minnesota Medicaid serves about 900,000 enrollees. About two-thirds of those are in managed care and one-third are in fee-for-service. Of the third that's in fee-for-service, about a third of those are disabled. Although our program is changing and as of this legislative session, we'll move the disabled folks into managed care with an opt-out available.

Minnesota has a history of measurement and quality improvement that dates back for years or decades. In Minnesota, we have a group called Minnesota Community Measurement, which actually is sort of the infrastructure for measuring quality across all payers, private and public.

We have legislation that calls for a Minnesota statewide quality reporting rule measurement system which is a required measurement at the hospital and clinic level. 2008 legislation has a provider-peer grouping that actually ranks providers by cost and quality, although that is not out.

Importantly, in the community measurement part, this includes direct data submission by practices, so it actually is a mechanism by which clinical information can be submitted to a common source and then audited for accuracy.

In the improvement world, ICSI, the Institute for Clinical Systems Improvement, has existed for, I think, about 20 years in Minnesota, and Stratus, our QIO, is active as well as our Health Care Home Program that's been evolving for about eight years.

What I want to talk about is this progression a little bit and that's our progression from a pay-for-performance program to a health care home. The health care delivery system demonstration is our terminology for our accountable care model.

And then I'd like to diverge for just a few minutes into evidence-based childbirth program. And I'll finish up just talking a little bit about the CHIPRA core measures which I have the privilege of being involved with, identification of the core measures nationally for Medicaid and then the Medicaid Medical

Directors Learning Network.

To start, we started with the pay-for-performance program a few years back I think about six years ago and it paid for optimal diabetes care and optimal cardiovascular care. This program was actually present across the market. And what we really saw was improvement in our scores over time and we also -- that really paralleled the improvement in the commercial payer program.

The unfortunate thing, I'll be frank, is that our scores went up and the commercial payers went up and the gap still remains, and we realized we have work to do to address that.

The second part -- I think I lost my headings here -- the second program that I want to talk a little bit more about is health care home and this is the medical home program, or the PCMH program in Minnesota. This was started by a 2008 statute and it involves a fairly rigorous certification and decertification process. And we, to the angst of some of Peggy's staff, did not initially adopt the PCMH standards because we wanted to do something different. And I'm happy to say that the new PCMH standards and the Minnesota standards are fairly well lined up these days.

But our standards are really -- really require clinic infrastructure and processes, and this is as Peggy talked about, whether or not we could actually use some process and infrastructure measures as a reliable indicator of progress.

The areas of the clinical infrastructure that we look at are access and communication, coordinated care, care planning for the appropriate patients, and quality improvement. We require outcomes to be reported and outcomes are required in our program for decertification.

So I think the hope in the Minnesota program is that you can be paid and you can get certified, but if you want to stay in the program, we are, over time, expecting that the outcomes are achieved and the outcomes are in the three areas of the three-part aim, health outcomes, patient experience, and total cost of care.

I mentioned the quality improvement process and I'll talk a little bit more about that. And we do require patient and family involvement in both their own care, but more importantly, in the quality improvement process, and I think that's one thing that we're particularly proud of in Minnesota, is that having patients and families in the quality improvement process at the clinic level really changes the conversation.

Currently in Minnesota there are 144 clinic sites that are certified out of approximately 700 primary care sites. So we've made a lot of progress in that regard. And approximately one-third of Minnesota citizens are covered by practices that are certified.

I want to talk a little bit about the payment for this so you -- for this as well. Our payment is really -- it's based on a per-member per-month payment, based on complexity. The payments are between $10 and $60 per member per month with an average of $31, and these are payments for patients with one or more chronic conditions.

And when we released our payments awhile ago and these have been approved by CMS, the same day we released them, we had one group from another state say to us, Well, we can do this for $3 a month and we had some folks from inside the state say, We need $300 a month to do this. So we thought, Oh, we at least hit the side of the barn here.

But I want to talk about this because it represents about 2 to 3 -- it could represent about 2 to 3 percent of the total health care costs for a member. So we are betting that we will have put enough funds in this that we actually change the equation and actually, as I sometimes say, move the battleship just a few degrees.

And that's important. Our payment also includes just a couple other things, just to mention real quickly. We have some additional factors that receive additional payment and they are factors that the providers felt needed more time to coordinate care. The two that we have right now, although there's a

push for more, are patients with serious and persistent mental illness and patients who do not have English as a primary language.

Private payer alignment is required in our legislation and there's a story behind that, but it's been progressing. And the other thing that's I think really important here is we report or we're working on, hopefully in the next few months, reporting claims-based data from the Department of Human Services back to practices. So we really are trying to complete a feedback loop back to practices so that the practices understand how they're doing compared to their peers.

And the feedback is on things that you would expect, but is really important. Things like hospitalization, preventable hospitalization, re-admission, ER, preventable ER, and total cost of care.

The next step in the evolution is really around what we call the health care delivery system demonstration and that includes -- that's really our accountable care model. That model, as I think both Gail and Peggy talked about, really is our attempt to build off of our primary care clinical infrastructure.

And I think one of the things we've tried to do here is say that the primary care payment will -- or the primary payment will be per the usual model of care, so that if somebody is in fee-for-service, they'll stay in fee-for-service. If someone is in managed care, they will stay in managed care. And then overlaying on that is the gain and risk calculation for a total cost of care calculation.

We are looking at quality as well as that so you won't get a full gain or risk share unless you meet qualify outcomes as far as clinical outcomes and patient experience. And we could talk specifically about what those -- we expect those to be.

And we also will use the same claims-based data to report back in as close to real-time as we can, which is probably about a two-month lag, to practices about how they're doing.

I think importantly, one of the things we're trying to do here is we're trying not to move from fee-for-service straight to capitation, because I sometimes think about that as a road where there's gutters on

both sides. You don't want to live in either gutter because there's problems. We really want to try to live on the top of that and not careen from one side to the other, which I think is something that people are thinking about.

I'm going to take a little diversion to our evidence-based perinatal program and then I'll hopefully finish this up. We actually realized, as a lot of states have, that there's a specific issue with the induction of labor for early-term pregnancies, babies between 37 and 39 weeks gestation.

And we really wanted to do something about this. We actually started looking at C-sections and found that our expert panels from our states that don't go after C-sections because the C-sections that we can prevent are the result of these early inductions that happen too early and then failure to progress.

So with the help of the community and looking at some work that was done in other states like Ohio, we actually recommended and got legislation passed this year that has the following things in it: A hard stop policy for early induction. So a hospital can't do an early induction without going to their medical director or some other process.

Annual reporting of elective inductions to the Department of Human Services. So just once a year to report. And local quality improvement activity, including an evaluation of all early term inductions for using local data. And I want to be clear that this is what we want them to do at their own site, not something we require reporting on.

And we require them to have an effective quality improvement site, process site committee, so we're actually asking for the same sort of quality improvement processes that we've talked about in the medical home. We have a very soft incentive here and that is that the hospitals that don't meet these requirements, the providers will be required to report individually on each delivery.

And I think one of the challenges that we have, as we talk about linking payment to quality is trying to figure out how hard to come down in terms of punitive payments or rewards. And I think this is where

we really, as I try to say here, trying to ride between being on both sides of that gutter. We estimate in the state that we'll save $2 million a year in state costs in this and $2 million to the Federal Government.

So just to sum up a little bit about what all this means put together, I put this on because this is the measurement continuum and I think this is really important for folks to understand that we look at measures of infrastructure sometimes, and I have examples here. So infrastructure for us is patients and families effectively on quality committees or even having quality committees.

Process measures are things like the number of care plans per medical home providers, so that they're actually doing that work. Health value outcomes are disease-specific outcomes that we hear a lot about, utilization of ER, hospitalizations, and then dare we even talk about this.

We should talk about health status, either the World Health Organization measures or care giver stress, because I think things like that are really what really makes a difference to folks, and especially when you talk about the duals and seniors and folks with disabilities.

I'm going to skip one slide and go to this. This is the theme that I think I want to really talk about a little bit and that's that our goal, I think, is really -- and I think hopefully the goal they can -- is really to have an iterative learning health care system.

And to do that, we need to do a couple things. Measurement is essential, but not sufficient alone. It has to be a link to effective quality improvement. And as I said, quality improvement processes can be an infrastructure measure. Measurement should be about learning at one level and about results in the at another level.

So we want results. We want things we can report from the states up to the Federal Government. But we also want -- I think we really have to pay attention to encouraging providers to measures to learn, either through their quality improvement activities or through small tests of change, things that will never be statistically relevant, but will be relevant in practices. That macro-aggregation of micro system change is

what I hope will actually make a difference over time.

We need to create partnerships between the Medicaid agencies and the providers in terms of feedback and in terms of supporting each other, and we need to align financial incentives for this transformation to be successful. So that's sort of what we've been working on.

If I can just take a couple more minutes to talk about a couple national things. And these are a little bit of perhaps shameless advertising. But there are, as I think most of you know, measurement sets that were to be identified in both the CHIPRA 2009 legislation and then in the Affordable Care Act. The CHIPRA legislation called for the identification of a core measurement set for child health measures for the first time in Medicaid, and in 2009, we convened that group.

The measures were selected and we looked at the following sort of parameters for measures, and I think this is just useful background as parameters for any measures. We ranked them by validity, feasibility, and importance. We looked at the measure of levels where, as I showed you in that previous slide, where the infrastructure measures process or outcomes.

Data source is crucially important because data burden is a huge issue. Populations served. So is this a measure for children with attention deficit or is it a measure for babies. So we had a comprehensive. And then the measure use and developer, which was very often NCQA.

We ended up with measures in preventive services, acute care, chronic conditions, and family experience of care. I won't go into that in detail. But I think these groups were very effective. We did the pediatric group, and the adult group is still working on its measures and coming up with its core set of measures as well.

And I think that the more we can align the measures that are being proposed by this group with measures that come out from other organizations, the easier it will be for providers and the more buy-in we'll get as well.

And then the last thing I just want to talk about very quickly is, I have the honor of being on the steering committee of the Medicaid Medical Directors Learning Network, and I think I'm here because of that group. The Learning Network has been in operation for about five years and is funded by the Agency for Health Care Quality and Research and administered by the Academy of Health.

Medicaid medical directors in states perform their roles of identifying and helping develop benefit policy, developing quality measurement, and working on all the system design components. The network role is really to support the Medicaid medical directors. It's really, I think, helped with longevity, with shared learning, and the Medicaid medical directors are represented on a lot of national and Federal groups.

And last, and I think very importantly, we as a group have started to and have an interest in doing projects of national significance. So the group has done a project to look at the use of anti-psychotic medications in children and has really started -- a lot of states have picked that up and legislation in the states has really improved that.

We're now moving towards looking at re-admission and also looking at the perinatal. And to just finish off, to tie that back into why all this data is important, it's very challenging at the state level to really figure out what's an apple and what's an orange, and things like duration of enrollment, what constitutes an admission versus a 23-hour stay, do we look at re-admissions at seven days, 14 days, 30 days.

All of those things are really crucial and we try to make that. I think the more we can line those up and have states line up, the more we'll be able to actually make progress. So thank you.

CHAIR ROWLAND: Thank you, and we couldn't agree with you more than to say the more we can make things consistent across the states, the more we can make progress. But also the more ability we have as MACPAC to make our work more meaningful. Questions? Steve.COMMISSIONER WALDREN: Maybe just a comment. I'd love to get your input if you think I'm right or I'm wrong. One of the things that I hear from people that are kind of outside the quality enterprise is they see quality

reporting measurement, performance reporting, and quality improvement to be kind of synonyms.

I think that's one of the things we kind of get into a problem, and you started to mention that little bit, I think, when you talked about on performance, we have to worry about all these outliers like if they never come to see me, as a physician, let's not ding them, which is that really true or not, isn't that a question.

But maybe just a comment about that because I think that's something that people that are not in the quality sphere kind of think of that, Oh, they're all just kind of the same thing and they're just reporting numbers.

MS. O'KANE: Yeah, I don't think they're the same thing. I mean, performance reporting and quality reporting -- I mean, performance can be broader than quality reporting, like ability to manage costs could be an aspect of performance. I would argue that it is and it ought to be. So that would be the most comprehensive. Quality reporting would be, you know, clinical quality, what do the patients tell us, and so forth.

And quality improvement, I think, is what people do to get better. And they may use the standardized measures, but they typically will often drill down below that. They'll need a lot more detail to understand how to get to where they want to go. And I don't even know if that's a complete taxonomy, probably not, you know, the kind of stuff that you're doing with lean I don't think -- I guess it would be quality improvement. But thanks for the question.

VICE CHAIR SUNDWALL: Okay, I'll be brief. Thank you for your presentations. This is a really good update on what you all are doing. My mentor for quality issues has always been Brent James, my friend at Intermountain Health Care who's been a national leader, of course. But he's frequently said that -- he said it's been a hard sell, but finally, after many, many years, he seems to believe that most people get it, that if you do the right thing at the right time, it will cost less.

Can you reassure us that -- I like what Steve called it, the quality enterprise. There's lots of people making money and doing fine on quality measurement, one way or another, however you choose to call it. Do you feel there's ample evidence, evidence-based that, in fact, all of these efforts cost all of less money in our health care system?

MS. O'KANE: Do you want to go first or do you want to go first?

DR. SCHIFF: You can go first.

MS. O'KANE: Okay. I think if you're not measuring costs and if they're making more money by doing more, then costs will continue to go up. So I think if you are trying to measure cost and affordability at the same time, I mean costs and quality at the same time, and you're held accountable for both or you live in a budget, then you can achieve high quality and have cost offsets at the same time.

But if you have a payment system that rewards over-use in all its varieties, that will continue to happen no matter what you do with quality, I believe, and I've come to that after a long time of reflecting on it, watching data and so forth. I'm pretty convinced that until it becomes the goals of the providers and the enterprises to make care affordable and that they are actually rewarded for that, it's not going to happen.

DR. SCHIFF: Thanks. I have this habit of asking my friends who practice more than I do who are -- if they could take 10 percent waste out of their practice. So easy, right? And very few people say no. I think everybody knows there's a lot of waste in their practices and there's just not enough incentive.

I think to get to your specific point, though, there are -- I want to be clear. There are specific populations that may cost more. We're starting an initiative called ten-by-ten and I'm not sure if it's national or not, but it's an initiative to improve the life expectancy of patients with serious and persistent mental illness by ten years in ten years, because their mortality rates are terrible and it's really from chronic illness, and I know that we'll save money on that, you know, over time.

However, I think the other side of this is, as we have rolled out our health care home program, we

have to report back to our legislature in 2013 that it's cost-neutral or it will probably go away. And so, now we have a huge mass of providers that are moving in that direction, and as we start to report out data to them about their cost effectiveness, they will have to be part of that.

So I think to Peggy's point, we have to ask them to look at quality and cost and be stewards of resources. I think that that's easily done, but it won't be done if it's not measured and expected.

COMMISSIONER MOORE: Both of you mentioned briefly behavioral health measures, and you're obviously starting one and you said there was a lot more work to be done. Can you just give us some general comments on the state of behavioral health quality measures across the board?

MS. O'KANE: I think behind, way behind. I think there are a lot of reasons for that. There's a lot of -- I mean, there are a lot of different types of behavioral health care providers. I mean, the roots of behavioral health care are often not empirical, right? Not that medicine in that empirical either.

But the evidence-based, what exists isn't even -- it's not harvested and it's not put into guidelines very often. So it's a very different state of development. So I think there's plenty of work to do. And, you know, actually if you've read Marcia Angell's pieces in the New York Review of Books recently, there are many, many questions about what goes on in behavioral health care.

So the point about don't measure things that you don't want more of is a very important caution in the behavioral health care world. And yet, we know these people are desperately in need of better quality treatment. So it's very hard.

DR. SCHIFF: Just a couple things. We did the CHIPRA measures. This gets into are we measuring what we really want to. We really measure things like adherence to medication, fills, and things -- and follow-up visits and things like that. So I think those are measuring things that we hope are useful, but we really don't know. And there's -- we actually put out a journal supplement around the CHIPRA measures and we had a real tough time looking at the quality of the evidence around behavioral health

measures and the link to quality.

The other thing I want to say, though, I think what I'd like to think we could go forward with a little bit is because, especially folks with serious mental illness, have a lot of health care needs, that we could look at their utilization of other services as a mechanism, as a proxy for whether or not they're -- hopefully for whether or not their mental health or behavioral health needs are being met.

MS. O'KANE: If I might just add to that point. I think there's a lot of over-use of psychotropic medication in children, and, I mean, I think it's tragic. It's putting these young lives at risk. I mean, the sequella, this kind of prolonged treatment, it's shocking. And yet, I think that it's really hard to find the true north here, you know. So we're planning to do more work in this area, but it really is fraught with difficulty.

COMMISSIONER MARTINEZ ROGERS: I just want to add to your comment where you see this most is with children who are in long-term treatment, residential treatment centers, of which we see this throughout the literature just talks about it, which then leads to health problems. So that is really something that we need to really bring up to par.

DR. SCHIFF: If I can --

COMMISSIONER HENNING: This is for --

DR. SCHIFF: I just wanted to comment that there's a report out that was written in conjunction with the Medicaid medical directors about this. It's really -- it's worth reading. It's about the quality of that, because we are very concerned about that as a group.

COMMISSIONER HENNING: And this is for Dr. Schiff. With your push to eliminate elective inductions less than 39 weeks, have you also noticed a decrease in your NICU admissions and NICU costs?

DR. SCHIFF: So our program takes effect -- the legislation passed this year. It takes effect January 1. We have already had a lot of hospitals come on board and say they're doing that. We have a

survey out right now -- it's still open -- about what hospitals are doing.

The estimated -- our estimated $2 million was a 60 percent discount over what we expect because we expect a lot of hospitals have already done this in Minnesota, and there's one study that looks at this nationally and expects across all populations a $1.1 billion savings in NICU costs, which is where we got our savings from.

COMMISSIONER HENNING: Okay, and then given that we know the induction of labor just alone increase your risk of a Caesarian section at least twice, you know, two times, what is the rationale for inducing labor without a medical reason at all?

DR. SCHIFF: We had that discussion a lot, and the one that comes to mind that everyone talks about is you are 38 weeks and three days and your husband is being deployed. You know, do you take that risk? So those sort of -- so there are non-medical reasons that may preclude a medical reason. So we're not trying to get -- we're not trying to say we get to zero. We're trying to say that we have to really think hard about it for the risk for the baby.

COMMISSIONER HENNING: I mean, even, you're 39 weeks and six days and you're tired of being pregnant. It's still -- there are some times when it's not good to mess with Mother Nature.

DR. SCHIFF: Right, and yes.

COMMISSIONER GABOW: Thank you both. I have several comments/questions. About waste in your practice, we have doing lean for six years, and when we started out, the people who do this in manufacturing said that 60 to 90 percent of every untouched process is waste, and I know that our physicians initially said, "Not at Denver Health. Maybe five percent." And now they believe that the 60 to 90 percent is probably correct. We have perfected the art in health care of work-arounds and we are now up to $119 million of hard financial benefit with lean since August of 2006. So I think ten percent is an underestimate. That is a comment.

The other issue, and Peggy and I have talked about this, is I worry about measure proliferation in the sense that as long as we believe that the way to measure quality is one disease at a time with the related interventions and outcomes, and you think of how many diseases there are, this number gets very large very quickly. So I really wonder if we shouldn't stand back and ask, are there surrogate things or approaches that yield the outcomes across the board rather than thinking about it one disease and one intervention at a time. It just seems to me that we have to go that way. Otherwise, we're going to find ourselves with thousands of variables.

The third comment I would make is I think if you really want to look at quality, it's hard to do without being in an integrated system, and the example I'll give is something that our State measures, which I think many people do, is post-surgical infections. We do very well at this, so I'm not whining, but I'm just pointing out that in our system, because our doctors are all employed and the clinics are all part of our system, if someone had an appendectomy and then goes to the community health center afterwards, that infection is reported. But for all the systems where the hospitals and the doctors are not connected, they go to their doctor's office, they get antibiotics, and that is never reported. So I don't understand how in the current fragmented system for a lot of these measures do we actually have any data validity.

And then my final question is to you, Jeff. Why not just do capitation? I just think there's added-on payment for a dangling participle sort of care. It's more administratively complex, actually has less flexibility, and is -- I'm not sure why it's better than capitation. So those are my comments and questions. Sorry for the --

MS. O'KANE: Well, I would recommend that you all go on a site visit to her place, because I went and I heard what you were doing and --

CHAIR ROWLAND: We've been asking for that.

MS. O'KANE: -- and I spent -- well, she'll do it. I know she will, because she did it for me and it

was just me, and then I sent my leadership and now we're trying to do lean, too, and it's incredibly impressive and it teaches you different ways of thinking about things that are really important.

I think your point about one disease at a time is really an important point. Unfortunately, the paradigm that we have for evidence generation is one -- we have institutes for diseases, right, at the NIH and so forth. But it really begs a lot of questions about what we're doing when we're treating people for multiple diseases, and there are trials that have shown that it's not necessarily adding up in a good way. So the point is really well taken. The burden problem is real.

I think one of the things that -- one of the logics we were trying to explore with the dual populations was to think about it like a tree. So are there certain core functions you would want to do for a person with special needs whether they were a frail elderly person, a mentally ill person, a disabled person? What are those things? And then maybe you might branch out with the special measures that only apply to that category of people. But that takes you into things that aren't necessarily thought of as quality measures.

But I think that, you know, we're in the early days of quality measurement and I think the danger is that we prematurely cemented in place with any one of our approaches. So we need to keep pushing and we need to keep hearing from people like you about what's not working, and also better ways to do it -- better ways to do it.

DR. SCHIFF: I think I'll go backwards and talk about capitation first. I think you sort of answered part of the question by saying, if we capitate and we teach for the test around some quality measures, which is what I'm really worried about -- because ACOs, in its worst sense, is capitation with a little quality thrown in -- then what we could end up with is good cardiovascular and diabetes measures but lousy care for kids with autism, or you could think of a zillion other things. So I guess I worry about whether in capitation we'd have a big enough measure set to make it worthwhile.

The other thing, then, is I really -- we have sort of made a conscious decision that we don't want to

exclude small groups from participation and small groups won't have the ability to handle necessarily capitation. The gain share we're doing in our ACO model is based on a total cost of care, but it doesn't put them directly at risk to start. So that's sort of the logic of why we do that.

Just a couple -- one other, just thing to mention along the other comments is I agree completely that we don't need a measure for every disease and we need some sort of surrogate measures around that, and I think what we really should try to figure out is whether surrogate measures that look at processes and infrastructure actually are valid for other problems. So don't send me a care plan that somebody who's got three or four complex diseases actually is healthier. And so that's the kind of work I think we need, because then it'll be great just to say, let's have these processes in place.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: Yes. I just wondered if either of you would care to comment on EPSDT. I know it's kind of a weak proxy for quality, but it's a Federal compliance requirement that's been around forever and --

MS. O'KANE: It needs an update.

COMMISSIONER HOYT: Yes. How can we make it more useful --

MS. O'KANE: It feels very, very antiquated to me --

COMMISSIONER HOYT: -- or should it just be scrapped?

MS. O'KANE: There's a lot of stuff in it that's not evidence-based, so I think it needs an update.

COMMISSIONER ROSENBAUM: Can you elaborate a little bit on what you mean? Which elements? Is it the screen that worries you? Is it the diagnostic and treatment services? Is it the reporting requirements?

MS. O'KANE: [Off microphone.] I'd have to look at the list, but I can get back to you on that.

COMMISSIONER ROSENBAUM: Well, I mean, it's sort of the -- it really is just the AAP

guidelines for health supervision. So it's an unclothed physical exam and developmental assessment, lab tests as appropriate, vision, dental, hearing screening -- what else is in there -- did I say developmental assessment. So I'm sort of not -- what I think is very problematic in EPSDT is what's measured. What's measured is only the element, you know, did you do the elements of the screening exam? Did you refer within a certain period of time? And I think some States are looking to capture -- I mean, you can see it in your own measures -- more health outcomes for children. Immunizations as appropriate, that's another element of the screening exam.

So I guess I look at the list of screening elements and I don't see anything there, and I don't know of any State that actually -- not since 1982 would any State -- there was a great exchange, just a little piece of history, in which there was an effort made to get rid of the screening elements and the director of the Mississippi Medicaid program singlehandedly saved the screening elements rule because, in her view, she could not -- this is in 1982 -- could not count on the clinicians on her State to undress all of the children. So unclothed physical exam stayed as a requirement of the program.

So I'm not -- to me, the big issues in EPSDT have come up around advanced diagnostic imaging testing, very complex treatments, and, you know, there, I think the issue that you guys were talking about before over medication, inappropriate treatment, I think, may be the place where some real attention is needed, because what you get is this combination of under-treatment of certain things and real serious and inappropriate over-treatment of other conditions.

CHAIR ROWLAND: Peggy, however, in response to Mark's question, if you want to provide us with any other –

MS. O'KANE: Sure. Sure.

CHAIR ROWLAND: -- information on that --

MS. O'KANE: Absolutely.

CHAIR ROWLAND: Trish was next, and then Andy.

COMMISSIONER RILEY: I just want to follow up on half the States are using HEDIS, which is, given our history, really great success, especially since in good times and bad financially. But I'd ask you each to tell us a little something about why the other half haven't joined in. What are the barriers, and what could be done to sort of --

MS. O'KANE: Because things are different in my State, I think is a big reason. And then I'm not really clear about what's going on in the other 25 States as a whole. I mean, I think the level of quality oversight varies a lot and it's probably not quite where it needs to be in a number of those States. But we're much more familiar with the States that we work with, so -- unless anybody --

COMMISSIONER RILEY: Jeff may know.

DR. SCHIFF: I think we -- if I could leave this Commission with something, I would say that data resources are greatly variable by State, and that is really the amount -- if you looked at the amount spent to look at quality in the Medicaid program compared to the amount that's spent altogether and compare it to any other industry, I think that it would be one of those graphs where you wouldn't see us on the bottom because everybody -- you know, we just don't spend -- we don't have the resources, and it's one of the things that always gets hit by budgets. So I think that that's really important.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: Yes, just to add to what Jeff is saying and Trish's question, our West Virginia stand-alone CHIP program is fee-for-service only, but because we do have a data warehouse consultant, we are able to report HEDIS data, and so I think it speaks to the point of whether or not you have resources like that. But I'm really glad that we could.

But I did want to ask if you're aware of efforts in States that help to report data at the plan -- I'm sorry, at the practice level in fee-for-service environments and what kind of infrastructure that takes.

DR. SCHIFF: The thing that comes to mind are there are a number of States that have all payer claims databases now that are, I think, pretty effective at gathering that information, and depending on the State statute, they have the ability to report, and so that tool may be incredibly valuable to move that forward at that basis.

COMMISSIONER COHEN: You spoke a little bit about the debate around using socioeconomic determinants and whether there should be adjustment in HEDIS measures for that. Can you talk -- I mean, you gave a really quick overview of what some of the considerations are --

MS. O'KANE: Yes, I know. Sorry. I --

COMMISSIONER COHEN: -- but can you go in some depth --

MS. O'KANE: I really glossed over a lot of really complicated things in that talk.

COMMISSIONER COHEN: But that one obviously has a huge significance for Medicaid.

MS. O'KANE: Yes. Yes. Well, let me just go to an example of how this played out in a particular program. There's a pay-for-performance program in California with the medical groups and the Integrated Health Care Association runs this and we are their measurement partner. It's very clear that certain areas, the Central Valley, in particular, in California has much lower scores, and I think people agree that it's a lot more challenging with the poor uneducated people that live there. So what they then did was to adjust the formula to reward improvement, and I think there's a part of the formula that goes for absolute performance and a part of the formula that goes for improvement.

But I would also point out that among the medical groups in the Central Valley, there's one that absolutely stands out from all the others and it just is -- I think it's Sharp, Sharp Rees-Stealy – and they have just -- you know, there are a lot of people in safety net populations and providers that don't take no for an answer, and I think we see examples over and over again of unbelievably great performance taking care of the poor and the people with disadvantages.

So I think that the idea that you just kind of say, oh, well, we don't expect as much, feels wrong, but it also -- I mean, I think what the IHA did is actually a reasonable place to go, you know, to kind of take it into account, but try to keep moving things up.

COMMISSIONER ROSENBAUM: I have a question, actually, it's for both of you. But I'm interested, Peggy, particularly in your views on it because I know this is an issue that you've struggled with for all the time of NCQA. I think one of the great advances for Medicaid under the Affordable Care Act is actually not directly Medicaid, it's that when your income changes, you won't be uninsured anymore. So for people who live at sort of the cusp of coverage, if things work the way they're supposed to, people will have a continuous source of affordable coverage.

My one big concern, and it's really not a concern, it's just sort of my sense of what we all really have to focus on, is making sure that the market for insurance affordability programs is integrated so that when your financial source of affordability changes, you don't find yourself being shoved back and forth among insurance markets, you know, between qualified health plans that only take premium assistance versus plans that only take Medicaid.

And one of the things that I've thought about as maybe an incentive in all of this is that we move more toward longitudinal measures of quality so that plans are incentivized into multi-market participation with the promise that you actually would get greater gains if you can show continuity of care over time, or the outcomes of continuity of care over time, and I'm just wondering, if we didn't face the kinds of interruptions that we've had, short periods of eligibility interrupted by periods of no coverage, can you imagine your HEDIS market basket changing? How might it change? And I wonder, Jeff, because of Minnesota's experience with broadened eligibility, of course, whether you've seen somewhat more stable enrollment and you've been able to think about measures that reflect continuity of care, which I think for this population is just crucial.

MS. O'KANE: I think I have to think about that one, because I -- I mean, I think the point -- your concern, I think, is very well placed. I do think that -- you know, a lot of plans are not planning to play in the exchanges. So I don't know how this is going to play out, and it probably depends on how the exchange is put up in each State. You know, the Federal regulations, I don't think are too much of an impediment, but I'm not so sure.

So I think that it obviously would be desirable to have people stay -- be able to stay in the same plan, and we've even talked about combining lives in our comments on the Federal regs. But what would we measure differently? I don't know. I don't know, actually. We'd have to think about that.

DR. SCHIFF: I would like to say that I agree about the idea of longitudinal measures. I don't know that we've actually sort of attacked that too much in Minnesota. We have fairly good enrollment eligibility, but we have a fair amount of churn, still. And unfortunately, when the budgets get tight, enrollment numbers go up -- you know, percentages go up and down, at least for certain populations, although that's changed a little bit recently.

I do think that the issue of even measuring duration of enrollment as a quality measure is one that we took on in the CHIPRA thing and we really realized that we need better -- we need a better measure of churn, actually, just from State to State, and I think that that would be something that -- should be something that we get to, so --

COMMISSIONER MOORE: I don't want you all to leave without just a shout out, if you will, to AHRQ for funding the Medicaid Medical Directors Leadership Network, which is a spectacularly wonderful group, as far as I'm concerned. I mean, it wasn't very long ago when Medicaid didn't even have medical directors. But now that they do in many, many States, I think it's a fabulous organization. They've done some very, very worthwhile work and I hope AHRQ continues to support you all.

MS. O'KANE: It helps us, too.

CHAIR ROWLAND: I wanted to also commend you on giving us the CHIPRA measures. We like what CHIPRA did to many things, including creating MACPAC. But I think your measures are also going to be very helpful to us as we look at performance standards.

Norma, did you have a comment?

COMMISSIONER ROGERS: I have a quick comment, and that is that I'm from the State of Texas and I'm also in mental health, and I frequently hear, and people actually call me from community-based agencies, that will call me at work and say, what are you doing about the number of cuts that we have in mental health in the State of Texas? And I'm sure that we're not the only State. But of how much the underserved population is being deprived of care.

CHAIR ROWLAND: Well, I think that measuring what goes on -- we've been left today, I think, with a few very important message, and I think Peggy's comment, don't measure what you don't want more of, and Gail's comments earlier about focus on the levers that you want and don't pay for the things you don't want and look at best practices, and the don't teach for the test, so we've got a lot of mottos to go with --

MS. O'KANE: You put the questions on the test, right?

CHAIR ROWLAND: Right. Always ask the right questions. What's the question? And I think that actually, what's the question, and then that helps you figure out the answers.

MEETING DISCUSSION WRAP-UP

* CHAIR ROWLAND: But this has been a very helpful panel and a very helpful day as we have looked at the issues here of how do we measure and obtain better performance standards, how do we look at getting the best value in the program, because in these times of limited dollars and in these times when cuts are on the table, this is a critical area for us to be looking at.

Tomorrow, our meeting is going to go on to look at some of the high-cost populations and the dual

eligible population, and we've gotten into some of those issues today. We'll get into them in more depth tomorrow.

And we also hoped to have done some work on program integrity today, but we will have to do that at our November meeting because this meeting was timed with one in which all of the people we wanted to have come speak to us were at their own meeting. But that, obviously, also has to really be a big piece of what we look at in trying to make the program more effective and efficient.

PUBLIC COMMENT

* Chair Rowland: So I thank the panel and we will now take any public comments that the public wants to offer, if you would come up to the mic, identify yourself, and make your comment or pose your question, we would welcome to hear from the public. But let's thank this panel especially, Peggy and Jeff, for coming here and being with us today and Jennifer for pulling it together.

[Pause.]

CHAIR ROWLAND: Do we have anyone who wishes to add more wisdom to the day?

[No response.]

CHAIR ROWLAND: Otherwise, we will then stand adjourned from the public meeting. Thank you.

[Whereupon, at 4:18 p.m., the public session was recessed, to reconvene at 9:00 a.m. on Friday, September 23, 2011.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

Friday, September 23, 2011
9:19 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
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

LU ZAWISTOWICH, ScD, Executive Director

P R O C E E D I N G S [9:19 a.m.]

CHAIR ROWLAND: Welcome. Good morning. We are pleased to continue our fall MACPAC meeting, today focusing on the high-need, high-cost populations in Medicaid and looking at various ways in which care can be delivered to this population, the respective roles of the federal and state governments, and some of the interaction between the Medicaid and Medicare program. So I am going to ask Christie to start us off with this morning's session, and I want to welcome Barb Edwards, the Director for Disabled & Health Programs Group in CMS, and the former Medicaid Director in Ohio, and a long-time analyst of the Medicaid program. And I would also like to welcome a current Medicaid Director, Julie Weinberg, who is with the State of New Mexico in the Medical Assistance Division; and Marty Ford, the Director of Public Policy for Arc, to really provide some beneficiary perspectives as well.

So, with that, Christie, please set us in motion.

HIGH-COST, HIGH-NEED MEDICAID ENROLLEES: FEDERAL, STATE AND BENEFICIARY PERSPECTIVES ON COORDINATING CARE

* MS. PETERS: Thank you. Good morning. Today's first panel addresses high-cost, high-need Medicaid enrollees. These populations, which include individuals with disabilities, children with special health care needs, and individuals dually eligible for Medicare and Medicaid, represent a small portion of Medicaid enrollment, but they have a large impact on program expenditures. They are diverse in terms of health status and their medical and support needs.

The Commission started its analytic work on these populations last year. In the MACStats section of our June report to Congress, the Commission reported that Medicaid eligibility groups such as non-disabled children and adults, individuals with disabilities, individuals aged 65 and older differ markedly from each other in their characteristics, service, and spending. We also reported that from 1975 to 2008 half of overall Medicaid benefit spending growth was attributable to Medicaid enrollees with disabilities. We reported that individuals with disabilities and enrollees age 65 and older, their per person Medicaid benefit spending is three to five times larger than that of other Medicaid enrollees. And we also found that

Medicaid enrollees aged 65 and older account for about 60 percent of the dual eligible enrollment and 60 percent of the Medicaid benefit spending for dual eligibles.

The Commission is continuing its analytic work in this area with population profiles and service and expenditure analyses of these populations. We will be publishing a basic document later this fall on Medicaid and individuals with disabilities that further explains what the patterns are for these populations and their subpopulations.

The focus of our first panel today is federal, State, and beneficiary perspectives on high-cost, high-need Medicaid enrollees, and federal and state programs and initiatives used to provide quality care and contain costs for these populations.

Our goal is to better identify high-cost, high-need populations, their impact on federal and state Medicaid expenditures, the challenges that federal and state levels face in serving these populations, as well as to present different perspectives on tools that States and the Feds have basically to achieve appropriate health outcomes and contain growing costs for this small but diverse group of Medicaid beneficiaries.

The information presented today is to inform ongoing Commission work on high-cost, high-need Medicaid beneficiaries and to guide the Commission's future work on these specific populations and coordination and integration of care, including policy and data analysis and research plans.

I am now going to turn it over to Barbara Edwards from CMS.

* MS. EDWARDS: Thank you. I was asked to provide a little bit of a profile of who the high-cost population is in Medicaid high-needs population, and so what I want to share are just a few slides that took a look at the top 5 percent of Medicaid spending and using 2008 data and what we learned when we looked at this sort of segment of the Medicaid spending, who is in that population that is driving -- who is the top 5 percent of cost, and we found that the folks that are in the top 5 percent of spending are driving 55 percent of all the spending in the program. So this very small number of people, 5 percent of the Medicaid population, are driving 55 percent of the spending.

And what we know about this population, on the next slide, is that they are maybe not who people think

they are. This population is largely younger adults, non-aged adults. They are principally adults who are 40, 50, 60 years old. As you can see, there are children in this group of individuals that is driving so much of the Medicaid spending, but it's largely a younger adult -- not a young adult, but a younger adult population.

There is a significant number as well of individuals who are over the age of 65; 24 percent are 66 to 85 years old and another 16 percent over the age of 85. So it is important that there is a pretty significant group of older individuals that are in this group as well.

When we look at the population in terms of whether they also have Medicare coverage, probably not surprisingly a significant number of this group is dually eligible, 54 percent; and the dually eligible population represents about half of the spending in this group.

The next picture that I want to show you -- and I'll spend a little bit of time on this one -- is what services are being purchased for this group of individuals in the top 5 percent. And what you will see, probably not surprisingly since I know this organization has been looking hard at the Medicaid program, is that there is a lot of long-term care spending for this population, both in nursing facilities and other institutional settings and in home and community-based services.

But what I want to point out is the difference in the spending between those that are dually eligible and those who are not dually eligible in terms of Medicaid spending, because when States look at this population, this is what they are going to see.

If you look at the dually eligible, which is the blue bar, you see a couple of things. The first is it is all about long-term care. And it is also all about nursing homes. One of the things we think this is reflecting is that in the -- we know that across the states there has been much more movement toward community-based services in the non-elderly, non-fiscal disability population than in aging and physically disabled populations. There is still a much heavier reliance on institutional care within the aging and physical disability populations than in the intellectual developmental disability group where there is a strong reliance on community-based long-term services and supports.

So one of the things I think we are seeing here is that for older folks more likely to be dually eligible, you are seeing the predominance of nursing home versus home and community-based services.

The second thing that I would ask you to look at is that when you look at the non-dually eligible population, what you see is a more balanced picture. You're going to see there is significant long-term care spending; interestingly, a heavier reliance on community-based than nursing homes compared to the dually eligible population. But also what you see on the right-hand side of the picture is significant spending for inpatient hospital and for pharmacy. And the reason I want to point this out is that, you know, this is, of course, the dilemma of the dually eligible population in that the truth is the dually eligible population spending also looks like this. It just isn't Medicaid spending. And so the acute-care spending is in the Medicare program for this group. And so it is easy to get fooled into thinking what you're dealing with with this population if you're a state, you think it's all about long-term care, when if you would combine the Medicare and the Medicaid data, you're going to see a picture that looks much more like what you're seeing there with the non-dually eligible population. So I just wanted to point that out because I think it does show some interesting things when you look at where the dollars are being spent.

So one of the things that's happening today is that states are paying attention to this population. CMS is paying attention to this population. And we are seeing a lot of energy being focused on what to do about high-cost, complex needs populations.

Next slide.

From CMS' perspective, this has been the goal that Don Berwick has set for us, and I'm sure you've seen this: that the goals for CMS and, in fact, the goals that CMS would see for the whole health care delivery system in this country is better population, better health care quality, and lower costs. And Don Berwick always says to us, "And you achieve those lower costs by doing those other things well, through improvements in the system."

So when we see states looking at this population of high-cost, complex needs, we are seeing a focus on issues about how do you improve care. Some of the strategies that states are using I think are very

consistent with the issues that CMS is pursuing, so I want to talk a little bit about what some of our strategies are.

In Medicaid, we sort of have three strategies I wanted to highlight today. The first is promoting improved service integration. One of the challenges of our health care delivery system often is that it is very siloed, and we have folks who do a very good job with acute-care services and folks that may do a very good job with long-term care services, but it's difficult sometimes to put it all together around the individual. So there is a lot of interest, and we are trying to promote interest in a more holistic approach to health care for complex populations.

We are seeing a lot of interest on the part of states to use managed care tools with this population. As states are coming forward in these difficult fiscal times, it's probably the single most -- not most common, second to provider rate cuts, we are seeing a tremendous interest on the part of states for the use of managed care strategies with folks that have high-cost needs and are either disabled -- disabling conditions or chronic conditions.

Some of that is what's now the traditional managed care approach of using managed care organizations. Some of it is new models of care that states are interested in. One of the new models is the health home opportunity that was presented in the Affordable Care Act. This is a new Medicaid service that's available, but it's really about a new organization of health care delivery around individuals with multiple chronic conditions or who have a serious mental illness.

There is a focus in the health homes around a holistic approach to health care looking at primary, acute, long-term care, and behavioral health care needs of individuals. States have a lot of flexibility in identifying who the health home provider is. There is 90 percent match for the health home services for the first eight quarters of a state's health home model. Health home services include things like care coordination, family supports, individual supports, transition services as people move between institutional and non-institutional services, and coordination across medical and social supports. So that's a new service opportunity that states have to put in place, and we have a lot of interest from states who are looking at health home models.

Probably half the states are currently working with us trying to design their systems, think about their options, and we have a few that have actually been files, and we are working toward approving our first health homes. We are very excited about it. SAMHSA has been a terrific partner in this effort, and there is a requirement that states consult with SAMHSA in the design of their health homes, even if the population target is not the seriously mentally ill population, because there is an acknowledgment of how important integration between physical and behavioral health care is in the design of these programs.

We see the Federally Coordinated Health Care Office, our duals office, paying a lot of attention to the issue of the need for improved integration of services, working with states, again, to be holistic in their approach to the dually eligible population, asking the hard question about what about mental health, what about substance abuse, and how are you thinking about long-term care. And we're seeing states being very responsive to those questions as they are thinking about their designs. And we see states coming forward saying, you know, we have been doing managed care for a long time in many states. We want to start looking at new models of delivery. How can we learn more about accountable care organizations? What kind of payment reform tools are available to us so that we could better drive the kinds of outcome and improvement that we want to see in health care delivery. And, again, a lot of that focus is on high-need high-cost, complex populations.

Next slide.

So the second strategy that we are encouraging and think have great value in terms of improving care and outcomes and costs in this high-cost population is continued transformation of our long-term services and supports delivery systems in this country. Many states have made tremendous progress. They have really led the way in terms of demonstrating the ability to provide services for individuals in integrated community settings. Some states still lag pretty far behind.

We have a lot of opportunities, a lot of supports at the federal level to help states make this transformation. Some of them are grant programs like Money Follows the Person, where there are enhanced federal dollars that provide increased FMAP for states as they move individuals from an

institutional to a community setting. States then have those additional federal dollars to reinvest in system transformation and infrastructure development. We're seeing a lot of investment in housing and the development of relationships with local housing authorities through the Money Follows the Person Program, and we're really thrilled about that.

There's a new provision in the Affordable Care Act that takes effect October 1st, and it's an opportunity called the Balancing Incentive Program. This is an opportunity for enhanced federal matching dollars across all the states' home and community-based spending for long-term services and supports. If a state commits to making some infrastructure changes -- no wrong door as an access approach to help people find long-term care services in the community and coordinate eligibility, conflict-free case management, and the use of functional assessments for individuals rather than diagnosis-specific assessments in terms of understanding people's needs for long-term services and supports. If states make that commitment and commit to moving their use of community-based services to at least 50 percent of their long-term services and support spending, there is enhanced match available to the states for a four-year period of time. Again, Congress making dollars available to help states make the infrastructure changes, particularly in balancing incentives targeted to states that have been lagging in terms of making these transformations in their systems.

There are some new service options that are helping to bring what used to have to only be offered through a 1915(c) waiver program for home and community-based supports. These services are now available in a variety of ways through state plan options if states choose to offer them that way. The newest is Community First Choice, an ACA provision that allows states to provide attendant services in the community to individuals as well as other long-term services and supports, with an enhanced match rate, 6 percent add-on match rate, which is permanent, built into the program -- again, trying to entice states to really seriously look at how they can rebalance their systems. 1915(i) is an option to provide the full array of what states used to only be able to provide through a (c) waiver, can now be provided through a state plan option called 1915(i); lets states have a tremendous amount of flexibility in targeting populations, in

looking at evidence-based practice and finding ways for Medicaid to support evidence-based practice. And we think that states are particularly interested in (i) as they think about their behavioral health populations. There's a lot of flexibility to do better care, we think, through this (i) model than some of the old tools in Medicaid.

We don't have a lot of states taking us up on this yet, but we are encouraging states to really take a hard look. There's a tremendous amount of flexibility there.

Section 1115 waiver template, I want to just mention that we are trying to find a way to make it easier for states to pursue the path that Vermont and Tennessee and some of the other leader states have taken in really trying to transform their systems and put community care first in their delivery systems, and we're working on a template.

The third major strategy is improvement in quality, and I'm going to mention just a couple of things. There is a tremendous focus on quality in the Affordable Care Act. Partnership for Patients is one of the initiatives out of the Innovation Center at CMS that is for Medicare and Medicaid looking at ways to help reduce unnecessary rehospitalizations of Medicare and Medicaid and CHIP folks. There is a sense there's tremendous savings to be gained from this as well as, obviously, the improved quality that if people get the right care the first time and they get help with those transitions the first time, there's not a need for that rehospitalization.

There are new quality measures being developed for adults in the Medicaid program to line up with the children's quality measures that were created under the CHIPRA act, and then Medicaid is moving into the development of quality improvement programs. We have quality improvement strategies already in some of our long-term services and support programs, our 1915(c) waivers, for example. We work closely with states over their quality improvement and quality assurance systems. But in the Affordable Care Act there is a tremendous focus on quality. There are quality reporting requirements with new Community First Choice provisions. There are quality reporting requirements with 1915(i). It is clear that Congress has really been supportive of the idea that we need to be thinking about these issues across the authorities in

Medicaid as we're looking at long-term services and supports, and our goal is to find a way that we can be consistent and more standardized across those authorities so that the states can have a single approach to this issue and it will work regardless of whether it is an (i) or a (c) or a (k) or whatever else the alphabet that states are using to bring these services to individuals.

So I'll stop there and welcome questions when you're ready for that, but it is my privilege to be here. We are happy with the movement that is taking place in states. We are thrilled to see states paying attention to these populations. And we really are looking forward to working with them as they find better models of care.

CHAIR ROWLAND: Thank you, Barbara.

* MS. WEINBERG: Hi. Chairpersons and Commission members, thank you for having me. My name is Julie Weinberg. I am the Director of the Medicaid program in New Mexico. I direct the Medical Assistance Division, which is part of the New Mexico Human Services Department. I am thrilled to be here to tell you about what we do in New Mexico and our experiences and our thoughts about where we want to go.

I want to set the stage a little. I assume that some of you have probably visited New Mexico, but for those who haven't and for those who might have forgotten, New Mexico is a very large and unpopulated state -- or "underpopulated" maybe is the word. We have 2 million citizens in the whole state. We have 121,000 square miles in the state. We have a population density of 17 persons per square mile. Half of our 2 million people live in Albuquerque metropolitan area, which, if generous, is about 3,100 square miles. So the rest are spread out through smaller cities and towns and very small villages. So you can imagine our very first challenge in serving any populations, and especially in serving our ABD populations, is the isolated and rural nature of our state.

Transportation is a big problem, and access to long-term services and supports, particularly things like respite, adult day health, and even finding personal care service givers in these rural areas is very challenging.

There are some things we're hoping technology can help us with, but keep in mind that a lot of these

areas don't have even good broadband Internet access, as some of you may know.

We're also a very poor state. One out of every four New Mexicans is enrolled in a Medical Assistance program that New Mexico Human Services Department runs. Five hundred five thousands are enrolled in our Medicaid program, which includes our CHIP and our QMBs. An additional 43,000 are enrolled in our 1115 HIFA demonstration waiver, which is called State Coverage Insurance Program, SCI. I'm sure you've heard of those.

We are the largest health care payer in the state, the Medicaid program is. And as Barb said, I'm sure you won't be surprised to hear that the elderly and disabled comprise 14 percent of our enrollees and account for about 42 percent of our program expenditures. So, again, they are of concern to us.

So we have a number of programs and services that serve our high-need, high-cost populations, and we've been at it for quite a while. Since the mid-1990s, we have operated a number of 1915(c) waiver programs. We run one for the DD population. We have a traumatically brain injured waiver, the medically fragile waiver, and a waiver for persons living with HIV/AIDS.

These four programs, there are about 4,100 persons enrolled. A subset of these enrollees can participate in our self-directed waiver, which we call "Mi Via," which in Spanish means "My Path" or "My Way." And some people end up turning that into an Italian-sounding word, for those who aren't good with Spanish.

We also operate a 1915(c) waiver for our disabled and elderly. It's part of our combined 1915(b) and (c) program called Coordination of Long-Term Services, or COLTS. There are about 3,000 enrolled in the COLTS. We call it the COLTS (c) waiver now, and these enrollees can also choose Mi Via if they wish.

Both our DD and our COLTS waiver have long waiting lists. We have about 5,500 on the DD waiting list and, hold on to your chairs or yourselves, about 14,000 on our (c) waiver wait list.

Now, we don't know a lot about the folks on our (c) waiver wait list. We're getting ready to start looking at them. We have recently -- we used to run the COLTS (c) waiver out of our Aging and Long-Term Services Department, and in June they came and joined us at the Human Services Department,

which should make for a better management of the COLTS program overall. And one of the things we're going to do is start looking at that waiting list to see who is on there, who is Medicaid eligible, who never will be. But even if it was half that, it's still a lot of people on that waiting list.

On the state plan side, we have a personal care option program. It provides for personal care services only. The program was implemented in 1999, and there were expectations for a few people to enroll, and it expanded exponentially very quickly. We call it the "woodwork effect." We learned the hard way on the woodwork effect, and we have about 15,000 people now accessing personal care option services through the state plan.

So people on the COLTS (c) wait list will often gain Medicaid eligibility and start accessing PCO services through the state plan side of things, and they get enrolled in COLTS along the way, which leads me back to COLTS, which is our (b) and (c) combo program.

So in 2003, in response to the rapid growth of the PCO program and just the high cost of LTSS in general, the Medicaid program leadership at the time decided to create this managed care program for the elderly and disabled, including all of our dual eligibles except for our QMBs. In 2004 an RFP was let. Four years of development work later, the COLTS program was finally implemented in August of 2008 with a full statewide enrollment achieved by May of 2009. We try and do it in a phased-in approach. We try the best served areas like the Albuquerque area, Santa Fe, and Las Cruces -- the large city in the southern part of the state - first, and then we go out to the more difficult areas, which, as you could guess, are our empty areas, our rural areas.

So there are just under 40,000 COLTS enrollees. Healthy duals are in there. They are entitled to state plan benefits that Medicare does not cover and our cost-sharing provisions. Our nursing facility level of care duals and Medicaid-only disabled individuals receive both the state plan benefits and long-term services and supports. The program has two managed care organizations, Evercare and Amerigroup.

The primary goals of the program are service coordination, nursing home diversion, community reintegration, and better management of home and community-based services -- all of this aimed at slowing

the growth of program expenditures and improving the care, especially on the home and community-based services side of things.

The COLTS program has reduced the growth of overall expenditures for elderly and disabled Medicaid enrollees in New Mexico. It's not that expenditures aren't growing, but they're growing at a slower rate. Growth in particular in this last year and the year before started to slow after we saw some rapid growth right away, which is to be expected. I can tell you the legislature wasn't real keen on that. They couldn't understand it. It's very hard to explain to legislators when you make a change like this what's going on because a lot of these costs were buried in other lines in our budget projections, and suddenly they see them all on this one line, and it can be a little bit difficult. So it politically has been kind of difficult for us to sustain the COLTS -- positive approach on the COLTS program.

The COLTS program really has been very successful in terms of reintegration and nursing home diversion. We continue in New Mexico to be one of the best balanced states when it comes to a percent of our long-term services and support spending spent on home and community-based services. Our two MCOs report that together they reintegrate more than 200 people each year out of nursing facilities, so this is good stuff.

And while we have achieved a lot in these COLTS programs and in the other waivers as well, we still face many challenges in serving our high-need and high-cost enrollees.

The glaring gap is the inability of COLTS to integrate Medicare and Medicaid services. We've got the duals in there. Sometimes I wonder why, because we haven't been able to do that integration. Now, what we found is that some of our folks who we first thought were "healthy" -- we called them "healthy duals" -- turned out to be, once they were assessed, in need of HCBS services. I know that's kind of redundant, but that's the way I say it. But then we still have our healthy duals, and we don't have that good integration there.

Our two COLTS MCOs do have their own SNPs, but enrollment in them is very low. We do have some homegrown SNPs, our Presbyterian Health Services in Lovelace, and they are very well known and

popular, and we can have folks in the SNPs for their Medicare side of things, and in one of our COLTS MCOs for their long-term services side of things.

What else do I have here? Our service coordination for long-term services and supports has been really good. We all agree, all the stakeholders agree that there is room for improvement on it, but overall it has been good, and it has really helped people find the services they need to stay in their homes. But we don't have that comprehensive care coordination across the acute-care side of things, and not to mention behavioral health as another part of that.

In addition, the fact that there are such long waiting lists brings a lot of concerns to me about overconsumption of long-term services and supports by the waiver enrollees who are lucky enough to be there, to the detriment of others who are equally as needy. We have a 30-day minimum NF stay for reintegration, and I believe we have some evidence showing that this is more of a gateway for people who may already have a lot of these supports available to them, and they run through -- they go in and they say, "I only have to be there for 30 days." They go out and back into the community. Meanwhile, I've got people languishing on the waiting list who aren't as lucky. We're going to be using our the Money Follows the Person grant to change that, so we really hopefully can start taking people off the COLTS (c) waiting list.

The program structure of a (b)(c) combo is a real challenge. We find the siloing effect of (b) and (c) services to be rather artificial. Running two waivers as a combo is an administrative burden for us. We have to manage both waivers separately, you know, reports and renewals and all of that stuff. And it just seems to us to be another barrier to the full integration of home and community-based services across the whole spectrum of care that people need.

And I kind of liken it to, like, when you have a combo sandwich, you don't only have the cheese on one side and the meat on the other, right? You have got it all stacked together. Yet what we have got are these two little silos. I like to paint pictures and I like to eat, so --

[Laughter.]

MS. WEINBERG: I can give you a couple of examples. How am I doing on time, Christie? I have got a couple of minutes. So I will give you one example.

We had the waiver. To get our waiver approved, we had to take the homemaker services out of the (c) side and use our personal care services as the (b) side, and so what we found is that our COLTS (c) members, well, homemaker services, housekeeping services, personal care services, that group of services are the most utilized services on the (c) side, but they're coming out of -- or our (c) members, but they're coming out of our (b) side of the waiver and we're starting to worry a little bit about cost effectiveness issues because we've got this additional utilization that we didn't have. So that's one problem.

We like to use adult day health services to create a bridge, kind of, between our very high PCO users and nursing facilities. They don't want to be in the nursing facility, yet if they're getting assessed for 50 hours a week, that's very expensive and indicates to us there's other things going on. Yet adult day health is not in our State plan. And most of the people in PCO are -- well, those are PCO services. They're on the (b) side. So it creates these silos.

Another issue we have is our PACE program. We have one small PACE program in the Albuquerque area. It's like this little island. It's not integrated into the COLTS program and we are hard pressed to figure out how to do it and we're not sure what to do about that. So those are a number of challenges that we're looking at in the COLTS program.

And so we've been asking ourselves, so where do we go from here, and I think we picked up a lot on what Barb was talking about. We have too many waivers. I think we counted, we have 12 altogether. We run 12 different kinds of waivers. We have our big b waiver on our physical health managed care program called Salud. We have a behavioral health managed care waiver. We have a bunch. We have too many.

So we're in the process-we've got to simplify it. We've got to be able to take all this administrative burden and minimize it and focus in on running programs and evaluating those programs, making sure they're working right.

So we're working on -- we're in the process of developing an 1115 global waiver request. We've been doing a lot of outreach to the community, to the stakeholders. As I speak, we're probably gathering around some work groups on care coordination right now back in Santa Fe. We want to do this to simplify the program, as I said, but we want to eliminate those silos of care, physical health, behavioral health, long-term services. We don't chop ourselves up that way. We're whole. We're whole people and so are our members, and we believe this will help us to improve our overall care and outcomes as well as continue to bend the whole program's Medicaid cost curve, our whole program.

Comprehensive care coordination, health homes, new payment methodologies, ACOs, the whole gamut will be at the heart of the program, and we certainly believe the comprehensive care coordination includes some kind of integration between Medicare and Medicaid so that we can stop the cost shifting between the two programs and focus in on the best outcomes and lowering cost as the triple aim.

I look forward to answering your questions as we go on.

MS. PETERS: Marty.

* MS. FORD: Thank you. I'm Marty Ford. I'm with the Arc of the United States. We are a national organization that advocates on behalf of people with intellectual and developmental disabilities and we have chapters across the country, State and local. I mention that because a lot of what I talk about comes from the chapters up to us based on their experiences with managed care and care coordination, and I'll be reporting what I am learning from their experiences.

But first, I want to talk about some basic points about the population and the field, where it has gone. Barbara has noted some differences in Medicaid and the development of the Medicaid programs for people with, as we say, ID/DD, shorthand, and then talk about some of those concerns that have been raised about care coordination and managed care as it has developed.

In terms of the characteristics of the population, if you are qualifying for Medicaid and for home and community-based services waiver, you have a very high level of care. Obviously, if you have a developmental disability, intellectual disability, by definition, you have a lifelong condition that has occurred

before the age of 18 or 22, depending on the body that is defining it. But it's generally 18 or 22, typically intellectual disability, autism, epilepsy, cerebral palsy, a brain injury. There are many, many, but those are the ones that most people know.

It will often but not always require 24-hour support or substantial support of some kind. It will change over time, often include complex or multiple conditions for an individual, and frequently require multiple interventions for that individual. But a person's needs can change over time, sometimes lessening, sometimes increasing, and that's something that has to be kept in mind over that individual's lifetime and depending on what their particular supports are -- family supports, community supports, supports in the workplace.

People with ID/DD are living longer and they are also developing issues related to aging. They're developing dementia. People are living longer than they had been expected to when we were ourselves children. Things that doctors at the time thought would result in an early death are not resulting in an early death, and so we have conditions that even the doctors don't know what they mean as people age.

And in particular, I want to point out, obviously, that children benefit from early intervention. The earlier you can get -- this is for all children, of course, but the earlier you can get appropriate services and supports and habilitation and rehabilitation and the right kinds of technology and supports to children, the better, and the more you will prevent the secondary and further conditions from developing.

In terms of the acute care system, we experience lots of issues. Many people with intellectual and developmental disabilities must use specialists as their primary care physicians, and that needs to be kept in mind in the development of a program. Low Medicaid provider reimbursement rates are a major barrier to care. It's extremely difficult to find specialists, such as neurologists, dentists, others, who are willing to take Medicaid reimbursement rates.

Many providers lack training in disability and they have inaccessible offices and inaccessible equipment. Children and adults who cannot use the equipment cannot be assessed. Women who need mammograms and can't get up to the equipment can't have those tests done. Children who need x-rays and can't access

the equipment, it's very, very difficult. This is just -- this is a daily occurrence in the lives of people with severe disabilities. Aside from the fact that there's a major question about whether they're in compliance with the Americans with Disabilities Act, I mean, it just means it's bad health care. So those are major issues that people face every day.

There are also, for people who have developmental disabilities, there are a lack of providers for adults. Many adults are still seeing their pediatricians because they grew up with pediatricians who understand them and who are still willing to see them because they can't find somebody who will address their needs.

And many people need help navigating the health system, dealing with notices, making decisions. You know, you're in a group home. They're not necessarily -- that staff is not necessarily going to be educated well enough to be able to help that individual or that family through that.

You also address the issue of training of staff to recognize the subtle differences in someone's behavior when a person who cannot communicate changes in how they feel or pain. You know, somebody has got to be well trained to recognize those changes in behavior. So there are a lot of things that have to be looked at when you're looking at this population.

Continuity of care is also critically important. You need to maintain the physicians and the providers who know people. That includes their habilitation and rehabilitation and mental health and behavioral providers.

I mentioned the communication issues. People who have intellectual disabilities may not be able to even understand health care, much less be able to report or understand symptoms and side effects.

And you have increased interaction time with a patient, and people need an access to the full range of medications.

In terms of long-term services and supports, our field, its programs, policies, statutes, regulations, have all moved toward principles of self-determination, self-direction, and person-centered planning. The Supreme Court's decision in Olmstead, insisting on the most integrated setting for each individual, all reflect a decades-long movement away from the medical model, and that is where we want to keep going. We do

not want to slide back into a medical model. And one of our States recently, just as an example, said if we have to look at the URAC requirements and the medical director has to be the head of the program, we are headed straight back into the medical model. It's going to make it more expensive and we are going to be sliding right back into medical everything.

Care coordination is already part of home and community-based waiver programs. I point out that medical necessity definition must be broad enough to cover long-term services, which is not a pure medical service. And just -- I don't have it written here, but as a quick note, I point out the second purpose of the Medicaid program -- it's in the first section of the Medicaid statute -- is for rehabilitation and other services to assist the individual to become more independent. It does not even use the word "medical."

So given the haste, I don't know if you know -- well, I just came back from a national convention and our office is moving. I can't even go to the office today. We don't have an office today. The movers are there. I neglected to print that in here. I meant to, but if you want me to, I'll type it up and send it in. But I think it's very instructive that we remember that the Medicaid program is not purely medical. It does contemplate all of the rehab and habilitation services that go with long-term services and supports.

Frankly, our field is very concerned about the possible loss of the ID/DD community infrastructure and the expertise that is very important and very needed for the population to continue to move forward and to have the kinds of supports that are needed. They are also very worried about the loss of local control and local supports to people. They are very concerned about the potential of large national entities taking over, over-medicalizing, taking away self-direction, person-centered planning, and turning what's essentially more local case management into larger and depersonalized, desensitized care coordination, frankly.

They are very worried about how to track the impact on quality of services and believe that functional improvements are not routinely measured or considered for individuals and that this needs to be done, and that there needs to be an inclusion of beneficiary experience measurements.

Moving a little bit further into the big picture concerns, managed care for long-term services does not, from our perspective, really have the same ability to reduce costs in the same way that acute managed care

may. First of all, preventing the high-cost services through intervention is not going to cure the condition. For people with ID/DD, the condition is lifelong for most. There are going to be people who move away, but for -- you have got a condition that's going to be there that needs to be managed, but you're not going to cure it.

And our experience also shows that many nonprofit providers are not making it on the Medicaid rates as they are. There's not a lot of fat in the system to be managed away. They are doing fundraisers to make up the difference between their Medicaid rates and what their actual cost of care is. So that's just a caution for what's actually going on at the State level.

I already mentioned that our folks feel very strongly, and these are the States who are in the middle of some of the managed care movements right now, that managed care is a very medical model and that this could take us backward. And I mentioned the issue of care coordination and case management.

Other big picture concerns, there needs to be a very strong, standardized minimum consumer protection process built into care coordination and managed care, and stakeholder involvement at every step. Behavioral health and crisis intervention needs, and the necessity of meeting those needs where the crisis occurs also needs to be built in. We really don't want to see people sent to emergency rooms every time there is a crisis. That can be particularly disruptive for people, especially people who have behavioral issues and for whom that is a major part of their lives. It shouldn't be a constant back and forth from a hospital emergency room. There needs to be a way of dealing with their needs on-site. And there will need to be a way to address the acute care, behavioral health care, and long-term services and supports together.

I echo what has been said about the waiting lists. There are waiting lists throughout the country. There are many people in the ID/DD community who are unserved. There are many who are technically in the home and community-based services programs who are underserved and the system is simply not serving everyone, even though the ID/DD community is clearly the population most served, I think, in the disability world, I think.

In terms of stakeholder involvement, one last point. Many people feel that there needs to be consumer representation on the governing bodies of the managed care entities and one thought is that -- just a final thought about where we have evolved over the last 30 years or so. In Medicaid, the ICF/MR program, which was once the largest Medicaid provider of services to this population, we've really taken that very expensive model which served most of the people and turned it on its head. That was where all the money was spent. That's where all the people were served, and it's been completely turned on its head and now the money is spent in the home and community-based services program and most of the people are served in that program for this population and we want to keep moving in that direction. We are already on a path of continuous improvement. And what we are hearing from our folks at the State level is, do no harm.

We are meeting on a regular basis with our State chapters in a working group, those who are dealing with managed care, dual eligibles, and 1115 waivers. As I say, I'm reporting what I'm hearing from folks. I would be happy to get more information to you, bring in a small group of them if you'd like to have any more interaction with them, get more details than I'll be able to provide in the Q and A, whatever. We make ourselves at your disposal. Thank you.

CHAIR ROWLAND: Thank you very much. I thank all of you for your comments, and now we'll open it up to questions. And Richard and Trish were in the queue already.

COMMISSIONER CHAMBERS: Okay. Thanks. First, Barb, I just want to compliment you on all the stuff that you went over, about the stuff that's going on in CMS with trying to reengineer home and community-based services. I really compliment you.

Two things, one thing you raised and another thing you didn't really talk about, and they're related in many ways. One is to talk about the PACE program, what you see as happening. I mean, there's a lot of focus on that program, its lack of scalability, and a lot of focus and a lot of corners on how PACE can be improved, expanded, meet the needs of this population. And while you only control one-half of the equation in CMS, I'm curious about your observations.

And the other related piece is on housing, is for those of us that are in the process of starting PACE programs, trying to get completely integrated acute and long-term care programs, including PACE, housing over and over again comes up as one of the biggest stumbling blocks, and CMS has historically had some waiver programs, such as assisted living, but where you think, you know, your thoughts of where there will be future changes in the program and opportunities for States to utilize more housing opportunities.

MS. EDWARDS: Sure. I'm happy to do that. You know, PACE is a program that is much beloved by my staff. I can say that it's the treat. It's the program everybody wants to work on. And that's been actually challenging in my shop recently because we've been having to move people around to sort of meet new needs and new program responsibilities and the loudest complaint always comes from those who no longer can do PACE. So I think people love it because they get a chance to get out and really see real people and be hands-on with the folks that are served by the program.

PACE is an interesting program. It is in some ways perhaps the model for our duals efforts because it is truly a single program. It isn't bringing Medicare and Medicaid to stand close together. PACE is a single program in the statute that combines the funding streams into a single benefit package, into a single financing approach. So it's got a lot we can learn from it in terms of its approach.

But you pointed out one of the big problems for PACE has been it has not proved to be scalable, and trying to understand why not has been one of the thing that we've been doing in the last several months under some interest by Don Berwick, saying what can we learn and could we do PACE better. So I think Melanie Bella's staff is also still looking at this pretty closely.

One of the challenges we know from consumer feedback -- first of all, PACE was by design targeted to a very narrow population base, frail elders. So it's not for younger ID/DD and it's not for folks that are 50, 60 years old. It was designed to be for people who are frail elderly. So one question has been whether PACE could be broadened in terms of who's eligible and would that help with scalability.

The second issue has been that PACE is built around a particular bricks and mortar site. It's built around a day care program, and there are some requirements around PACE, including that people who

enter the PACE program have to use the PACE providers. Some folks don't want to give up their doctor in order to get this great new combination of services.

So there are some structural things within the PACE design. While it was evidence-based, and that's been one of the advantages of PACE, is it was an evidence-based model that was brought whole cloth in, some of that evidence-based practice is also perhaps what makes it less scalable to a broader population to meet people in more settings and different needs and what they might prefer in terms of their care.

So it's something we're very interested in. I think that the duals folks are looking really closely at the lessons learned. And we'd love to see if there aren't some ways to figure out how to both build on PACE and also promote PACE as it is. Pennsylvania is a State that has done a lot of PACE development, so it's one of the States that we're interested in talking to about what makes it work in Pennsylvania.

But PACE is very small, and so the administrative cost over the small number of people that gets served is also one of the things that States have said to us kind of prevents people from going aggressively after that. So we're trying to look at those as lessons learned for the new duals effort.

With regard to housing, I think if you talk to anybody in the country that's trying to deal with promoting more home and community-based opportunities. How can we do better community integration? If you asked them what the barriers are, they'll tell you it's housing and it's housing and it's housing. And the issue is both affordable housing, but it's also about accessible housing for populations and safe housing.

So there is a huge issue, and I've been really thrilled that over the last couple of years, the administration has been working very hard to develop a stronger focus on housing as a part of transforming the long-term services and support systems. Secretary Sebelius has formed a tremendous partnership with the HUD, the Secretary of HUD, Housing and Urban Development. Henry Claypool at the Office of Disability at HHS is working very closely with Fred Karnas at HUD and we have really begun to see some results of that partnership.

There are some new vouchers that have been focused for non-aged individuals with disabilities who are living in the community or transitioning back to the community. There is a new Section 811 housing

program that HUD has announced that is actually focused on a new model of integrated housing, that instead of it being a housing complex for people with disabilities, it's about multi-use housing strategies that dedicate some units for people with disabilities so you don't have a segregated approach to community housing.

We have been providing States with the ability through money follows the person grants to create housing coordinators within their State system, both at, like, at the leadership level, at the Governor's office level, as well as at a community level. And our Real Choices Change grant program this year was also focused on promoting -- creating those local collaborations around housing between Medicaid and local housing authorities, and we are -- I think early next week, we'll be announcing six States that have won grants in this round of Real Choices and they're all focused on creating those local housing relationships.

So I think the Federal policy and certainly State attention recognizes housing as a critical issue and we're trying very hard to bring all the Federal resources, at least, that we can toward that issue.

HUD has also recently announced that they are going to repurpose housing vouchers as they come available, as they turn over, that had originally been targeted to disability housing and perhaps have gotten lost from that purpose over the years as they turned over, and HUD is identifying those slots and saying, we are going to repurpose them back to the intention.

So there really is movement. HHS and HUD are actually sitting down together, both at the leadership level, but also at the staff level, to learn each other's programs so that we can do a better job of helping bring services with the housing, which is really what's needed if you're going to make progress.

Now, clearly, it's not all a HUD issue. HUD can't do all things in terms of housing. But there is, I think, a high level of attention being paid to those issues and trying to help States create a local infrastructure that will be more supportive of solving some of those housing issues.

We've really seen in money follows the person that that has been sort of job one for States, is to figure out how to work more effectively with local providers, with organizations like Centers for Independent Living at the community level who really have some idea of where the affordable, accessible housing is in

that system.

I actually think this is a focus of the Department of Justice as they're looking at Olmstead compliance, Americans with Disabilities Act compliance in public programs like Medicaid. They're also running up against the issue that -- the issue is, well, we can't figure this out because we can't find housing. So, frankly, DOJ is looking hard at the housing issue and are actually helping to point out to States, there are solutions to the housing problem. You can pull these resources together.

So it's a huge issue. We really welcome ideas that folks may have about what we can do to better support States in overcoming that challenge.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: This is sort of frustrating. It strikes me that we've been working at this for 40 years. I remember in the 1970s and 1980s doing assisted living and congregate housing and home-based care. So it's wonderful that it's all coalescing and coming together because it is very, very exciting.

I was intrigued with, Barb, your page two, the five percent is 55 percent. I wonder -- because I think part of the problem we have getting our arms around this is the diversity of the populations. We now understand --

MS. EDWARDS: It's hugely diverse.

COMMISSIONER RILEY: -- so much more about the elderly and physically disabled who sort of fit one pattern. But the other categories that so nicely show up here are kind of black boxes in terms of what works best and what we can do, and I wonder if there's utility for us as a Commission, and maybe this is better for Christie, to take the second chart that shows the aggregate and break it down by group. I'd like to see behavioral health, ID/DD, and the different groups and where the spend is, because, in fact -- and I dare not venture into this very far with Marty here, who's an expert -- but the ID/DD thing is the biggest black box to me for States.

And Marty, I agree that the managed care models that work for acute care probably won't work for

ID/DD populations, but I'm a little nervous about some of your assertions because it doesn't mean there isn't efficiency to be found in them. In fact, when I look at the budget that I'm most familiar with in Medicaid, that's where the money is, and the per member costs. Of course, these are high-need populations. You'd expect it.

But we need to know the PMPM by population group and then we need to know what works. There's a lot of great assertions, Marty, in the back about what works, what doesn't, what we need to be careful about. I don't know where the research is. What works for an ID/DD population? And we seem to have more and more populations that are fitting into this big box with Asperger's and the other kinds of diagnoses. What works with behavioral health? What works with these populations who are so costly, so challenging, and who have profoundly complex needs?

And before we leap too far into managed care or hold too tight to the status quo, I think we need that research, and I don't know where it is. But I think a good starting point would be to break down and disaggregate this data by these subpopulations because we really can't talk about long-term supports as if all the people who need them are the same.

MS. EDWARDS: Trish, I would second that, and we're happy to work with MACPAC to figure who's got those resources and that information and how can it get pulled apart, and to also underscore that there is a significant acute-care spend here as well that may be in the Medicare program if it is not showing up in the Medicaid program. So really understanding how to get better health care for folks is -- I think Marty was even point out there can be -- you know, some systems are really good at the life support. They may not understand how that diabetes could be better managed. They may be really great at dealing with behavioral health and not understand the danger of that weight gain for the population from the drugs that are life savers for behavioral health.

So this issue of trying to figure out -- and doctors' offices are full of patients who for some reason can't seem to follow the path that the doc is laying out for how to manage the heart disease, and it's because we're not dealing with behavioral health challenges in that person's life. So we've got to get better at looking at

the whole person, and it is a good question of what models work. We're starting to get some experience around physical and behavioral health, in part because SAMHSA has been doing some experimenting and others have been doing some experimenting. Foundations have supported some of this. But I do think that in the intellectual disability and developmental disability world, we maybe have been less focused on trying to solve some of those problems.

MS. FORD: And I think that one of the things I was trying to say is that in the long-term services part of it, it has been managed in many, many ways through the ID/DD service system. The long-term service portion of it has been. That's where you've seen through the home and community-based waiver -- you know, the state agencies have in many ways operated as sort of a managed care entity in managing the supports. You know, I don't say that that's also managing all of the health care pieces of it the way that Barbara is describing. But I think the long-term services is where I'm talking about there's not a lot of fat in the system. You'll find outliers.

COMMISSIONER RILEY: I guess part of the problem, too, is the environment. It's a tough environment for states to work in. Maybe mine is a biased view and a narrow view, but it's a very advocate-rich community, and you do a great job for these populations, which is great because they can't speak for themselves in many instances. But it's also a highly litigious one, and I don't know how many consent decrees are still out there. It's a tough environment to have discussions about new ways of doing business in collaborative kinds of ways if you're always afraid you're going to get sued. And I think that may be the state perspective that sort of makes it a tougher population to move with.

COMMISSIONER GABOW: I have a couple questions and then a personal reflection about our safety net and how things work there.

Since we know that every other developed country is managing to care for their population at half the cost, and since we know this population that we've been discussing in its myriad components accounts for a substantial amount of cost, what I've never heard -- and maybe it's just because I don't know anything about the field, really -- is: What are other countries doing to manage this population more efficiently, at lower

cost, with better outcomes? Because it would seem like no matter what we look at, in other countries they've managed to do better outcomes at lower cost. So what do we know about this in the rest of the developed world? That's one question.

My other comment relates to our experience -- for those of you who don't know me, I run Denver Health, which is the main safety net in Colorado, and we have a committee called Complex Discharge, which meets every weeks and reviews all the people who have been in our hospital way past their medical need. And last week we totaled up the dollars that are right now people in the hospital who don't need to be there, and it's $10 million in acute-care hospital costs for people that we have no ability to place outside of an acute-care facility. And the common issues are people who need long-term care or could maybe do home and community-based service, but they have serious behavioral issues. They're violent or they have a criminal record or, you know, go down the list. And what's amazing to me is hospitals can't refuse to take a patient, but it appears that any other facility can come in, do an interview, and say, "Hmm, Mrs. Smith isn't our kind of patient," so Mrs. Smith stays. We have people in our acute-care hospital who have been there a year.

And the other interesting thing about that is if a long-term care facility decides that a patient is too much trouble, they get sent in by ambulance to our hospital, but you can't send them back. There's no return ticket. And this seems to me like -- there's no EMTALA-like thing around long-term care, and somehow that creates this tremendous misuse of high-cost resources.

The second experience that we've had relating to behavioral health is all the other hospitals in Denver have closed their psych units, and the state has also downsized their psychiatric care. So adolescents with developmental disabilities show up in our ER, and we really have no place to care for them, and there is no place to care for people. So it's always interesting to me from a CMS point of view that the EPA wouldn't let you drill an oil well without looking at the impact on the frogs, but hospitals can close psych units with no discussion of impact on patients.

So where does CMS' role lie in, you know, how hospitals choose to deliver or not deliver not-profitable

services that still may have a huge community need?

I'm sorry to whine, but these seem to me to be big issues that I don't know what bailiwick they fit in.

MS. EDWARDS: Terrific observations and questions, and some of which I have heard before and, actually a couple of which I haven't had people talk to me about since I've been at CMS, so we should talk some more about part of what you're seeing.

You know, it's interesting. There are a lot of concerns raised about too many people ending up institutional or long-term care, and I think it's related to the challenge that you are highlighting, which is often the easiest place for someone to go after a hospital in terms of the system is an institutional long-term care setting, that nursing homes are better organized to accept quickly, are better able to deal with the financing questions after the admission than community-based systems, and community-based systems often have to get kind of built around an individual. There may not be as much capacity that's sort of sitting there, ready, available, and able to take somebody within 24 hours.

And so one of the biggest challenges that I think states deal with as they try to change the direction of their long-term care programs has been the question of how do you have a community capacity that is able to respond more rapidly to the discharge need rather than saying, "Oh, I'm glad to know Mrs. Smith needs care. Give me six weeks and I can organize a team and find a place, and we'll do those things."

So I've heard those issues before. The idea that folks can't get out at all because even the institutional placements aren't available is not an issue that people talk to us so much about, so I'd like to learn more about that.

COMMISSIONER GABOW: I would be delighted [off microphone].

[Laughter.]

MS. EDWARDS: We'll be happy to talk. I really would like to hear more about that because that sort of relates obviously very clearly to unnecessary utilization of certain sources.

I think that the question about what hospitals can choose to do or not as private businesses is more within the bailiwick of states and their own licensure provisions as well as possibly Medicare and Medicare's

conditions of participation. And I hate to duck it, but Medicare's conditions of participation is not my area of expertise. But I think if there's an interest in learning more about that, we could certainly help facilitate getting the right people available to talk about what the federal requirements might be around hospitals, at least as a condition of getting Medicare, because that's really the only relationship that federally we have with providers, or other kinds of federal financial support.

MS. WEINBERG: You know, one of the things we've tried to do in the COLTS program with our MCOs is identify folks that are acutely ill or need a place to go afterwards, and also to stop the "let's just send them to the hospital" idea that the nursing homes have. That's a real cost driver. So it's definitely something that the COLTS MCOs have worked to reduce through the service coordination and knowing the members and identifying the really high-risk members. It's also what we're trying to achieve with our Section 2703. We're working on a physical health/behavioral health health homes for those folks whose primary health care is with a behavioral health provider, but who also have other chronic conditions to try again to prevent them from going into the hospital in the first place and creating community-based systems of care. We're also working on that with our adolescents as well. We recognize that is a big problem and ends up costing Medicaid quite a bit of money.

COMMISSIONER GABOW: [off microphone] Could someone please respond to that question?

MS. EDWARDS: I only know enough to be dangerous, so I do know that we have, for example, had some interaction with countries like Germany where early on there has been a focus on providing people with basically a cash resource that individuals can then use to buy and arrange their own care, and it seems to have been popular and effective in that country. We have some versions of that in Medicaid in cash and counseling and some other consumer-directed care, and a lot of that has been modeled on the ideas that countries like Germany have put in place that give people maybe a little less money than they might get if they came through the fee-for-service kind of program, but gives individuals much more control and find that people are often happier, are able to get services for a smaller amount of money, and have better coverage because they're actually arranging their own care providers rather than relying on agencies that

might be having staffing problems. So there are some of those --

CHAIR ROWLAND: There is a literature on some of the international experience with long-term care, and that would be a great assignment for us to give to our staff to report back to us at our next meeting on what some of the other models are. Sara had a question, though, quickly.

COMMISSIONER ROSENBAUM: Yes, thank you, everybody. Every time I move back to these issues for any reason, I am absolutely stunned by the blizzard of legal authorities we've got at this point, and I am wondering whether CMS has some sort of inventory that can let us see quickly the various legal authorities in the Medicaid statute at this point as well as related demonstration authorities, along with sort of a brief explanation of the basis of the authority, meaning what its purpose is and how it operates; and if not, whether we might ask staff to do that, because I am feeling, quite frankly, overwhelmed by the notion of our having to make recommendations in an area where I can no longer even get my mind around all the things that are technically possible except for all the limitations on them. I mean, that's the dilemma that we're in. We have so many legal authorities to act in this area, but each one comes with, very often, you know, some quite justifiable limitations on their scope. But before we know whether the limitations are redundant, whether the limitations inhibit other changes, whether the limitations are working at cross purposes with other legal authorities, I'm feeling as if we need something in front of us that shows us what the different levers are that are available at this point, and what populations they apply to, what services they apply to, the conditions under which they can be used, and the limitations on those conditions.

MS. EDWARDS: I would just like to say we have some of that, but given really the comprehensive nature of what you're asking for, we will have to work with you, though we are happy to do that. I probably shouldn't even say this out loud, but I have to say I've been telling people occasionally I feel like I'm the keeper of a toolbox of misshapen tools, and they're all kind of better than what we had before, but they've all got something -- it's like the head of the hammer is not quite big enough or, you know, the wrench only has one size. So it is a real challenge. We've gotten better and better tools all the time, but they all have limitations. And so I think that is a good exercise.

COMMISSIONER ROSENBAUM: Right. There are many, many challenges for all the other populations in Medicaid, but we don't face this particular problem. You know who's eligible for Medicaid, it's children, and sort of what the benefits are that they're covered for or pregnancy-related services. Here, because it's a system delivery challenge as much as it is a financing challenge, it is as if we have this pile to sort through first.

MS. EDWARDS: And we have an institutional bias. A lot of these tools have been given to us either through waivers, and to states, or now through new state plan options about trying to overcome the fundamental structure of Medicaid in which nursing facilities is a mandatory benefit and none of the rest of these things are. So that is also where it starts a little in a different place, I think, than acute care.

MS. WEINBERG: And, you know, the states -- the toolbox needs operators. All those tools need to operate, and that's us at the state level. And we're losing staff. We can't hire more staff, and to manage each one of those is a real burden. It sort of takes another person or two.

COMMISSIONER HOYT: That could be a good preface for the question I had, I guess for anybody on the panel who would care to respond. So duals are in the news this week in conjunction with the Super Committee on deficit reduction. There were figures tossed around, I think, of $120, $125 billion in savings. And I was wondering about your reaction to that. Do you feel like the savings are reasonable? Where would the savings come from? And were there any key changes or assumptions behind that that we should be aware of?

MS. WEINBERG: You know, I don't know if it's reasonable or not. I just heard about it this morning because I was in the air yesterday and then worked last night when I got here. But savings from a Medicaid state point of view, the savings come where you stop duplicating services, I think, and where you can identify your high-risk members, reduce your readmissions on the acute-care side. I think there are savings to be had on the acute-care side. On the long-term services and supports side, I'm not sure. We're exploring that now in development of our waiver, but the $125 billion sounds awful ambitious.

MS. FORD: I wish I could respond, but we were involved in packing our offices yesterday and could

not look at that stuff. Sorry.

COMMISSIONER HENNING: Okay. This is probably for Marty, maybe for Julie. As a women's health provider, what we find is that we have trouble with our ladies that are on Medicare providing them with birth control services because Medicare was originally set up for elderly people who didn't need birth control. But now when you have an intellectually disabled person that is on Medicare only, there is no provision for that. And then if they're on both Medicare and Medicaid, what ends up happening is that Medicaid says, "Well, I'm not paying for anything that Medicare won't cover," which typically is the actual device for the birth control. Or they will pay for the device because they consider it to be a pharmacy item, but they won't pay for the actual insertion of the device, so they won't pay for the provider or the provider visit because they don't recognize those codes under Medicare.

So this is a big problem for access to birth control of women of child-bearing age that have disabilities, and that's not just intellectual disabilities, but that's disabilities period. And so it just doesn't seem to me that anybody seems to be aware that this is a problem for that population.

So that's just more or less a comment, but have you heard that in your ladies that they're having trouble getting birth control?

MS. FORD: I had not heard that specific problem with the Medicare/Medicaid issue.

MS. WEINBERG: In New Mexico we cover -- for a dual eligible if Medicare doesn't cover the service, we do cover it. Where it would run into problems would be your qualified Medicare beneficiaries. But I used to be on the fiscal agent side, and I remember solving a couple of those problems even for our QMBs finding a way to get those paid. We do cover that and would pay for that. That's my experience.

COMMISSIONER HENNING: I hear that both from midwives in Texas and Minnesota and Florida. I mean, I hear from all over the country, so, you know, it's not just an isolated instance. It's more than one state.

MS. WEINBERG: It could be just problems with the way the claims are being processed. I mean, it gets into kind of some sticky wickets in terms of just the administrative side of getting a claim paid.

CHAIR ROWLAND: Well, we certainly have covered a broad range of topics with you on this panel and I think have learned a great deal about where the toolbox needs to be refined and I think given Christie a little more work on some international as well as national statistics and comparisons that we want. But I want to thank the three of you for joining us this morning and especially for the work that you're doing on behalf of the populations that you're serving. So thank you very much, and we'll have our next panel to look more from the provider side at these same set of issues. Thank you.

Okay. We are going to take a short break while the next panel comes up, maybe five minutes, if we can try and be very targeted. Thank you.

[Recess.]

CHAIR ROWLAND: Okay. If we could please reconvene. We are pleased to welcome our next panel and to continue our discussion about taking care of the high-need, high-cost, extremely complex Medicaid populations and the role of coordinated care programs. I am going to turn the panel over to Christie to introduce the panel.

ADDRESSING THE CONTINUUM OF CARE NEEDS FOR HIGH-COST, HIGH-NEED POPULATIONS

* MS. PETERS: Thank you. Our second panel today will focus on addressing the continuum care of needs for high-need, high-cost Medicaid populations. As was discussed in our first panel, there are a variety, I believe a blizzard, of authorities available to states to better coordinate and integrate acute-care and long-term services and support for various high-need, complex, high-cost populations, including managed care, home and community-based waivers, medical homes, PACE program, and Medicare Advantage special needs plans.

The Commission has begun examining certain models of care for specific high-cost beneficiaries, notably managed care for ABD populations and PACE and Medicare Advantage special needs plans, or SNPs, for dual-eligible populations. Last year we convened an expert panel to identify key issues in Medicaid managed care, including programs for individuals with disabilities, and issues integrating acute and

long-term services and supports. The Commission's June 2011 report to Congress included discussion of issues related to Medicaid managed care and individuals with disabilities and individuals dually eligible for Medicare and Medicaid.

Today's second panel will examine programs that strive to provide a continuum of care for our high-need, high-cost Medicaid populations. Joining us for this panel are representatives from provider entities that have experienced serving individuals with disabilities, dual-eligible populations, and medically fragile and complex children. We have with us today Ms. Aileen McCormick, who is CEO of the West Region for Amerigroup; Dr. Mary Gavinski, who is chief medical officer at Community Care, Incorporated; and Ms. Pat Votava, who is the manager of the Medically Fragile Children's Program at the Medical University of South Carolina.

So I would like to now turn it over to Aileen.

* MS. McCORMICK: Okay. Good morning and thank you so much for inviting me to be here. I'm delighted. This is a topic that's very near and dear to my heart. As Christie said, I am the West Region CEO for Amerigroup, which serves Texas, New Mexico, and Nevada, and within those three states we have approximately 100,000 aged, blind, disabled members that we have been taking care of in Texas since 1998, both non-duals and duals. So we've learned a lot over the years. We still have a lot to learn. The whole integration of SNP with our duals is an exciting topic that I'll share some thoughts that I have relative to our experience in having been doing that since 2006.

I'm going to run through these first couple of slides just to give you some context about Amerigroup, our model, and some of the key program components.

So basically we were founded in 1994. Our sole purpose is serving publicly sponsored programs. We are not a commercial managed care plan. We have approximately 2 million members in 11 states, soon to be 12, with Louisiana. And we do serve, in addition to traditional Medicaid moms and kids and pregnant women, CHIP and the ABD program as well as SNPs in the seven of the states in which we operate.

Next?

That is just a geographic, you know, sort of visual of where we are. The one thing I would like to sort of highlight is we are a national managed care organization, but we are very locally driven, and you'll hear and understand, I think, more about what that means as I get into service coordination. So, you know, I like to look at it as we sort of have the best of both worlds. We've got the resources, the ability to share best practices across our states, but we do understand that health care is very locally delivered, and so you'll hear more about that.

This is just intended to highlight. The ones in green are those where we have ABD and SNP plans. In Texas, as I said, you know, we have approximately 80,000 members, and we'll talk about some of the challenges with the take-up rate on this SNP integration with our dually eligibles.

Okay. So this is sort of the heart of it all for us, and I've heard the word used a lot since the earlier panel as well, so it's one that you all are familiar with. But service coordination really is at the heart of what we do. It's a local operation. We hired service coordinators on the ground in every market we're in, particularly for our ABD population. They include doing in-home assessments. Back to some of the earlier points, we do understand and it is critical to understand that this is not about a medical model. It's a functional model. It's about providing the home and community-based services and supports to basically avoid unnecessary acute services with an ABD population.

In Texas we do integrate physical and behavioral health. You heard Julie talk about New Mexico does not. Our bias is more integration is better. Texas recently received good word from CMS that we will have another waiver that will allow us to carve the inpatient risk back in. That was carved out in 2007 because of some UPL issues. And we have been responsible for still managing that, although not "financially at risk" for that because of those UPL barriers. It gets back to some of the blizzard of legal entities and some of the challenges. We were able to figure out a way to work around that and still provide very good care and results for the State of Texas, so much so that they are expanding statewide with their aged, blind, disabled program as well as managed care in general across the entire state.

What we use basically is sort of a hub-and-spoke approach, so our service coordination is a team. And

it could be that the lead person isn't an RN. It could be a social worker in many instances because what is needed for that member is really more about home modifications, ramps to ensure safety, grip bars in the bathroom, attendant services, emergency response system in the event of a fall, et cetera. They have actual, however, certainly, to teams of acute-care specialists -- nurses, case managers, NCQA-accredited disease management programs -- so that we can provide a holistic benefit to that person, recognizing our biggest objective is how to keep them living independently in the community.

We've had a lot of success around this approach in reintegrating folks. Julie spoke to the results in New Mexico, similar results in Texas where every year we track every month how many folks we're moving out of nursing facilities and into the home surrounded by home and community-based services. And that can take the shape of an independent apartment. It could be back into a family settings but with the appropriate supports and services that provides for that. It could be an assisted living facility. But really our goal is more independence is better.

We also track our diversions from nursing homes, so the folks that we identify with unmet needs, provide those services, surround them with those supports and services so that theoretically -- and I think it has proven to be true -- you avoid an unnecessary nursing home admission.

One of the things that we struggle with and talk a lot about is measuring quality within this population, and one of the things we did in February was roll out an iPad solution for our service coordinators, which now we've rolled out statewide in Texas, and we've got a strategy to do that in all of the states where we have this program. And it really is going to allow us to take this to the next level.

The metrics that are critical are, in fact, nursing facility diversion, reintegration, use of home and community-based services, seeing the downward trend in the acute-care services. All of that is real important, but we feel like there's sort of the next level that we're going to be able to get to by having an automated tool to really track and trend the things that we identify through the in-home assessment, over time to see what the results of the services we've provided to support that member, how have they worked, what are some trends we're seeing related to reduced falls as a result of putting grip bars in and things like

that. So very exciting and topical in light of sort of where we're trying to go with this population and measuring quality related to it.

Next slide?

So this may be overly simplistic. I'm not a clinician, but here's how I do look at this, and in the nine years I've been with Amerigroup, I feel like this really does work.

For us, we have duals and non-duals, and in Texas it's about a 50-50 split. So for our non-duals, we do provide everything. We oversee the physician, the acute care, home and community-based or long-term services and supports -- the holistic view of that person. But we have duals, too, and we only get one-half of that, right? Because the Medicare provides the other.

Well, it was really exciting for me personally, for us as a company, when the SNPs rolled out in 2006 because for us what it felt like we were able to do is treat a dual like we do a non-dual, right? Because now if they enroll in our SNP and they are in our Star Plus program or in our COLTS program in New Mexico and in a SNP, we can provide the full continuum of services, both acute and home and community-based. So it allows us to have sort of the holistic view on a dual that, up to the point before SNPs were available, we did not. And so it seems like a very natural extension for us, from our perspective, and we think that, you know, there are some opportunities on how to sort of put that a little bit on steroids in terms of getting it to the next level of taking advantage of how to get more folks into that program in a way that is acceptable for those members, certainly. But we think that just by our own results, when folks enroll in our program, we see very low disenrollment rates, particularly in the aged, blind, disabled category, and even, quite frankly, in our SNP where there is a lot more noise with direct marketing and folks knocking on their door and such that you don't have in our Medicaid world.

Next slide?

One of the things I was asked to just sort of comment on -- and I did reflect on this. This really is some of the challenges and opportunities in working with that provider community. I worked on the commercial side for about 25 years before I got religion and moved to the Medicaid side, as some of my

folks like to tease me, and it really is true. It's a very rewarding space to be in. And one of the things that we learned very quickly -- and when I joined the company in 2002 -- the whole world of home and community-based service providers is not like what you do when you're a commercial player doing provider relations and contracting. These folks, there's a lot of mom-and-pops. You have some larger players, but the reality is, in order to make sure you've got a good set of access points for the members that we served, you need a lot of the mom-and-pops in. A lot of these folks are hand-to-mouth, so claim payment is really critical. So, you know, when a company would get excited because we pay 90 percent of the claims in 30 days, which is what our contract says, well, that may not cut it for our home and community-based service providers, so we use a different metric. We're not contractually obligated to it, but you know what? If we want to have a happy network of providers, we darn well better figure out how to pay them in 14 days and not 30 days.

So, you know, the training. I have folks who are expert in working with this group of providers, and we will do training four to six times a year, remedial, a lot of hand holding, a lot of one on one, because many times those coming from fee-for-service were not accustomed to using standardized claim forms and billing in ways that, you know, the state requires when it is using HCFA's UB forms and such.

So we have really tried to figure out ways to be creative and innovative, to pretty much minimize the disruption or abrasion for this provider community so that they can feel good about us as a contracting entity, because as some folks have sort of indicated, we could be a scary thought for some people, right? Like the big, bad HMO coming into town.

I will tell you the gratifying thing for me is, with Texas expanding statewide, the community that came to the table first were the long-term services and support providers. They know we're here for good reason. We're trying to do the right thing. We're mindful of their special challenges, and it really takes that understanding and really working very closely with that provider community to get their support. And then what that does is it translates to the advocacy community. If you're doing the right thing and you're getting folks on home and community-based services and keep them out of nursing homes and your model

is about independent living, well, folks like Bob Kafka will have lunch with me and support what we're doing and go to the state with me about how we do more of it. So that's sort of -- you know, how do I measure quality? That's one bullet point for me.

Next slide?

These are just some things -- and this isn't just Aileen's world, but it sure is Aileen's world, but Amerigroup as a company, you know, has really spent a lot of time and has a lot of ideas in support of improving the SNP integration with duals.

As I said, you know, the marketing one at a time is costly, it is confusing, and it is challenging. When we rolled out SNP in 2006 in Houston, CMS, to their credit, allowed for a passive enrollment for our members. It is still the market we have the highest enrollment in because of that, but there was a lot of noise in 2006. Part D rolled out. There was tremendous confusion. There were some very aggressive marketing tactics. And this is a population that has already challenged in many ways, and so having a bunch of people knocking on the door making promises made it just very difficult. So we did see quite a big migration out and then now back again. But I really do think and Amerigroup does believe that, you know, some type of passive enrollment with an opt-out -- because, quite frankly, I'm perfectly comfortable with that. My service coordinators, they develop personal relationships with their members. So if someone is in and they're in for the holistic view, they're going to want to stay in. But they need to get past all the noise to be able to have that opportunity.

One of the other things is around provider network requirements. I think there is an opportunity -- and I've talked with some folks about -- you know, the MA rules around provider networks are not necessarily in line with what a SNP needs for a dual-eligible population. My members are not in the wealthiest parts of Houston or Austin or San Antonio. They are in very impoverished areas, so I may not be able to get a physician in Memorial or River Oaks to enroll with a SNP because they certainly don't want my members migrating over to their officers. So that then creates an access -- you know, geo access, trying to get approval, we can't do this.

So we find that there are counties we don't even bother to submit for SNP expansion because we know if we don't have every county, we get no expansion, and it's very frustrating. And I think that that is a very easy opportunity for folks to sort of get their arms around and really look at in a way that -- not trying to harm the member, but let's not create unnecessary barriers to be able to advance the notion of integrating with a SNP. And that and the passive enrollment idea would simplify and reduce administrative costs because you don't need a marketing machine, right? You don't need a huge number of marketing -- I don't have marketing in Medicaid. I have community outreach folks. I have folks who do a lot to give back in the community, but they're not out marketing Medicaid. Well, there's a lot of folks still marketing Medicare, and marketing to a dual-eligible I think is not necessarily the best approach to enrolling them into a SNP program.

VICE CHAIR SUNDWALL: Aileen, I don't want to interrupt much. I just want you to explain "passive enrollment." You have your auto enrollment with opt-out. I'm not familiar with the term.

MS. McCORMICK: Sure. Sort of same thing. So if I have in a market SNP licensure in Harris County, and within Harris County if I have 2,000 Star Plus members that are duals, there would be a passive enrollment of those 2,000 into Amerigroup's SNP for our Amerigroup Star Plus members, but then they have 90 days to opt out. You don't lock them in, but we really do find that if they can get past the noise and enroll with us, they stay. So that's what that means.

VICE CHAIR SUNDWALL: Okay.

MS. McCORMICK: The other, in terms of simplifying and reducing administrative costs, I'm probably preaching to the choir, right? If you integrate as opposed to stacking one on top of the other, you're going to reduce administrative costs, and that's really critical. As folks have pointed out, reimbursement levels aren't so great in Medicaid to begin with. You know, we need to be looking at every opportunity to streamline that and reduce those.

And then from my perspective, you know, I do think states need to be able to take the lead in this integration. There are a lot of ideas. I've met with the Office of Integration and Melanie Bella, and, you

know, the letter's out there for states to respond to in terms of the LOI on the three-way shared savings model. I think we just have to be careful that we don't undo some of the great work that may already have been done in many states, particularly in my region, where, you know, these states put us through a very rigorous process for bidding and contract award. If we're the plans providing the dual eligible on the Medicaid side, you know, let's not now set up a whole other system that someone else is going to decide who were the players on the SNP side.

So I think there's some of that that, you know, I would be very encouraged to see CMS and states working well together and comfortably, with good oversight, you know, by CMS for the states, but letting the states take the lead on that integration.

I think I'll stop there and welcome any questions once my two other colleagues here have their opportunity. Thank you.

MS. PETERS: And now we are going to have Dr. Mary Gavinski from Community Care, Incorporated.

* DR. GAVINSKI: Well, thank you very much for having me here. I'm really excited. I was so excited to hear the presentation before this. I am the chief medical officer at Community Care, and I'm going to talk a little bit about me. Then I'm going to talk about or organization and then some of the challenges about making PACE move into the 21st century.

When I was four years old and finishing my residency in geriatrics training, I was on an academic faculty position, and my dean sent me out to On Lok to see the PACE program, and I came back and I said, "Oh, you're going to be sorry. They needed a PACE physician, so they contracted for my services." In Milwaukee, we were one of the first four replication sites. This is in 1990. And so we started the PACE program, and three years later, as the program grew and my academic program continued to grow and I had two of my three children, I had to make a choice. And my heart was with PACE, so I came on as their primary care physician and medical director as an employee in 1993. I have been able to keep my clinical appointment, so we do a lot of teaching of residents and medical students and nurse practitioners in our

program.

And there's one other story I want to tell you about, and that's about Mrs. A., who was an 85-year-old patient of mine, one of my very first patients in my outpatient clinic as an intern. She lived alone. Her son was six hours away in St. Louis, and she had congestive heart failure. She had arthritis in her hands and a variety of other conditions. And over the course of my residency I saw her, and we really could take pretty good care of her in the outpatient setting.

But then she started to become -- her congestive heart failure got worse. Her legs would swell. She would get infection in her legs. She'd end up coming into the hospital, going into the nursing home, back home, rinse and repeat, about six times in the course of about 14 months. So I talked to her and her son and said, "You know, you might want to think about the PACE program." And so she enrolled in our PACE program.

Over the course of the ensuing about eight years that she was with us, she was in the hospital one more time. She stayed in her home until the last 14 months. She developed Alzheimer's at about the age of 95, and we could provide services in her apartment, but she really needed more care. And so she came into our group home, and we put in palliative care at the end of her life, and I got to be her physician through that whole time. She had the same care providers through that whole time. And I can tell you, without this model of care or this type of model of care, she would have been in long-term care placement, no doubt about it, probably within -- you know, seven years previously, eight years previous to that.

In addition to that, she would have been in and out of the hospital repeated times, and this was a fiercely independent woman. I learned more about geriatrics from her than I did in my training. So that's a little bit about me, and, of course, you can hear my bias about the whole thing.

Community Care is a private 501(c)(3) not-for-profit started in the 1970s, and really the program was set up to provide services, develop programs that would keep frail elders and adults with disabilities in their homes. So they develop a program, they might run it for a while, and then they would spin it off or maybe continue to run it.

Then in the 1990s, we were one of the first four PACE demonstration programs. I think this slide -- it must be formatted a little funny. Maybe just go to the next one.

So this is a pictorial view of us. Community Care is the parent organization, not-for-profit. It was a small social work case management organization when we started, really didn't know anything about primary or acute care or medical care, and I had to take a little umbrage from the woman from Arc who spoke, although I understood completely what she said, but for the last 25 years, I've been fighting both battles. Our PACE organization has been fighting both battles -- the medical side saying the medical side is the only one and we don't really need to talk to the long-term car side; the long-term care side or the social service model saying we don't want it overmedicalized.

Folks, we can't do it with both together. Equal playing field. I mean, it has to be both, and they have to be working together side by side, respected side by side.

So, in 1990, we started our PACE program. We now serve in Wisconsin two counties. We have about 1,500 members. The State of Wisconsin loved the PACE program, but they felt that they wanted a program where -- the same type of a program that they could have people 18 years and older and also that would work in rural Wisconsin. You can't have a day center. You might not be able to have all community physicians. So in that program we have about 600 members in eight counties, and then the State of Wisconsin in 2005 decided they just wanted to do capitated long-term care services, so they developed what they call the Family Care Program, which is, again, risk-based, capitated, 18 years and older, just the long-term care services. We have about 6,000 members in that program.

All together our revenue this year is going to be somewhere about a half a million dollars; next year I think it's going to be about $750 million [sic], and we're sometimes in the black. You know how it is, Medicare and Medicaid.

I'm going to really quickly just go through this because you guys know about PACE and understand what all of the issues are about not integrating both the long-term care and the primary and acute care together. Fragmentation is terrible for quality, duplicative services, and it's not the most cost-effective way

to do things.

Okay, next slide.

The integrating funding is really one of the most important concepts because you can't do that cost shifting -- and I can tell you, even in our own program where we have a Medicaid long-term care service side of things, what do I hear about? Maximizing Medicare. So you know that we're not looking necessarily on that program to really provide what is the most cost-effective and what is the best service for that. It's really about how does this business entity provide care. And I hear the same thing on the SNP side. So you've got to integrate it to together.

The other beauty about integrating the financing together is that whole creative, innovative piece of PACE, and when I talk about what are the key elements, we can provide services that Medicaid and Medicare don't pay for because we pool it together and we decide what you need to pay for.

For example, in Wisconsin occasionally they provide for dental services or some dental services, and then they don't provide for dental services. Well, as a person who cares for people who are elderly or have physical or developmental disabilities, they need good dental care. They need good basic dental care, or they're going to get sick. It's going to be more costly. They're not going to have good-quality outcomes.

So through the course of all of that, I just said we're going to do it; we're going to figure out how to pay for it. Where we had areas where we couldn't get dentists because -- and I understand, Medicaid dentists -- when I looked at what Medicaid pays the dentists, I understand why they don't want to necessarily do that. But we developed our own dental operatory because we couldn't get enough dental providers and also that difficulty in having some of our members served in the dentist's office. They're just not set up for people with a lot of functional disabilities. So when you combine it, you can do those kinds of creative things and find the resources to be able to do it.

So the PACE model -- and this is what I've been telling people since I heard about the ACO and the medical home. We are the original ACO. We are the accountable care organization. There is nowhere else where we can go for extra resources. So we are really needing to do what is best for that individual.

And when we get a new employee, what I tell them is you've got the luxury and the beauty of being able to provide what every member needs. On the other hand, you have the responsibility of doing it in a cost-effective way, because if we give everybody a power-operated vehicle and a brand-name medication and bring everybody into the day center seven days a week and get physical therapy every single day, then we're not going to be able to continue and we'll go broke.

On the other hand, if we don't see people soon enough, if we don't bring them into the day center enough, if they don't have access to the doctor or the nurse practitioner right away, they're going to get sick and go into the hospital, and that's going to be a quality problem for them and also a cost for the organization.

If we don't give families what they need, if we don't give them the respite they need, if we don't give members the equipment that they need, again, they're going to end up having a functional issue. They'll probably have a fall, something bad will happen. And so the alignment is correct, the incentives are correct, both to be cost-effective and to provide that excellent quality.

So I'm glad that CMS is looking at doing Accountable Care Organizations, but I really hope that they're looking at some organizations that really know how to do it and understand what are the key aspects of it and what are some of the pitfalls of the current PACE model.

Longitudinal care delivery spans time, setting health care boundaries, all those things you've heard before. I think you can just go to the -- this kind of puts it all together.

So when I was thinking about this, what are the key features of PACE or the key features of our partnership program that is a SNP with the long-term care services, is number one that it's member focused. So there can't be a one-size-fits-all. We use guidelines. Our teams have pathways that they can use to think about how to provide care, but they've got to look at that individual member. Where are they at? What is their support structure? Who is at home or isn't at home, et cetera, et cetera.

That holistic interdisciplinary approach to care -- essential -- and that really means, as I said before, the home care worker, the driver, the dietician, the social worker, the nurse, the doctor, they all have to have

input into that care planning and it has to be on an equal level, not a medical model, not a social model. It's an equal, holistic, truly interdisciplinary approach.

It's a comprehensive approach, and that comprehensive approach, again, is all inclusive. We need to evaluate our members when they come in and know exactly what their medical conditions are, exactly what their social situation is, exactly what their behavioral health needs are, or we can't serve them. The duals and especially the frail duals are too complex to pull one piece out. That's why I cringe whenever I hear about carving out behavioral health. That's ridiculous. I mean, you just can't do it. You can't provide the level of care that you can. It's got to be as integrated as it can be.

High quality outcomes, absolutely important. That's what we're looking at. That's what, when we look at our teams, when we give them feedback about how they're doing, it's what are the quality outcomes look like.

It's the flexibility, creativity, and innovation of the PACE model of care, and the reason why we can do it. It's not rocket science. It's because we have integrated financing and that allows us to be able to do it. And I'm not going to repeat myself.

[Laughter.]

DR. GAVINSKI: So the issues and challenges. You heard about, you know, there aren't as many people as we'd like in the PACE program, and why is it, and you heard a little bit before from the woman from CMS about what were some of the things that she thought about that. I also think that the prescriptive regulations, you know, I remember fighting tooth and nail to become a provider type, and it was a good thing. It was exciting, 1996, I think, because then we thought we had arrived.

But I remember, if any of you know Marie-Louise Ansak, she's the mother of PACE and she said, "Careful what you're asking for," because the minute we became a provider type, of course, they took the PACE protocol, which was kind of put together in the mid-1980s and built the regulations from that and it really is too prescriptive. It is too -- it's built on what was happening in the mid-1980s in both, I think, long-term care arenas and in the primary and acute care. So there are elements of it that are really

wonderful, but there are some elements that I think really have to go back to the drawing board and say, let's get some flexibility.

I think the role of the physicians and NPs are a big part of that. We have a waiver that allows us to use NPs or in addition or doing some of the things that the physician has to do in the regulations, but we have to get a waiver. Programs shouldn't have to get a waiver to use NPs. You know, NPs have been -- Mrs. A, Mrs. A had an NP before she had me and my geriatric training came from Mrs. A and that nurse practitioner.

Nurse practitioners are integral, I think, to growing PACE. Being able to serve people in a rural area -- we have to contract with community physicians in a rural area. There aren't enough physicians in that rural area to serve all the people who are living there. We can't ask them to become an employed physician.

The team composition is also something that I think needs to be looked at, not that everybody doesn't need to be there, it's just that you don't necessarily need 12 people once a week for two hours for every single member on a team. What we see is for the first nine months, when people come in -- three to nine months, depending on the person. A lot of people come in with a lot of needs -- medical conditions, psycho-social conditions, really, they need a lot of services. Once the teams get them in order, they go into a maintenance phase and they then may bounce in and out of it. So there has to be access and there have to be touchpoints, but I don't think it needs to be as much as the regulations say. So some flexibility there.

Care planning is another piece of it. Care planning was built, if any of you were in the nursing home or in the hospital system you understand about paper care planning. Well, the current way CMS looks at care planning is a very snapshot of time. Well, we have EMRs now. My care plan is up to date all the time. Yes, I have to take a snapshot to say are people meeting those multidisciplinary goals, but I don't think we have to have it be a duplication of where their medications are up to date, their problem list is up to date. I think that it could be streamlined, again, to allow us to be able to serve more people more robustly.

And then the day health center -- integral, very important, especially in urban areas, to have that. I think most people who develop PACE are going to want to do that because it's a cost-effective way to

provide a lot of services. But it shouldn't be absolutely you have to have, or in a rural area where it just doesn't make sense to do it. So, again, those are the kind of things.

I think the -- and we've heard about this several times this morning already -- the duplicative, the sometimes contradictory Medicare and Medicaid reporting requirements, audit, and language is ridiculous. We spend so much administrative time getting all of those things into place and the teams -- and it even takes some teams' time because they may have to document in a certain way for Medicare and in a certain way for Medicaid. So again, I'd rather have that money and spend it on more quality initiatives.

Financing changes that are coming that are meant for the fee-for-service models. This actually has me quite concerned, and I'll tell you why. We're doing it on the State side and they don't know how to integrate the two. So they want us to go back to reporting things like we did in the fee-for-service world. So does Medicare. And then if they start paying us in that way, well, teams don't operate in that way. Doctors don't get paid to be at family meetings. But in the PACE program, doctors and the family meeting can be a really important part. So that's something that we really have to keep an eye on

Better models for financing, the capitated programs for the DD and PD population. I really believe that the PACE model of care, or the Wisconsin partnership or SNP model of care, which is based on this, really does work for those populations because it's the same -- holistic, capitated, looking at interdisciplinary. But we really are going to have to make sure that the financing on the Medicaid side understands that population because it is a lot different. The community-based services cost a lot more, and when you're taking the frailest of the frail, you don't always get that bell-shaped curve.

And then doing the changing to outcomes based versus process based auditing, especially on our CMS audits. I think they could learn something from JCAHO there.

MS. PETERS: Thank you, Mary.

And now, Pat Votava.

* MS. VOTAVA: Good morning. Thank you for inviting me to be here with you today. I'm honored to present a program that was developed sort of as -- looking at the PACE program and then

looking at, okay, how would this model work for a pediatric population of high-cost, high-user children. It's great to follow Mary because a part of the presentation really was a look at, okay, what works with PACE for this population and what wouldn't work for PACE.

This is a program that was developed in South Carolina. It started in 1997, ended up spinning out to three different sites in South Carolina. Two of those were urban. One of those were rural. An all-inclusive program for medically complicated children aged zero to 21, and it started out with just a population of medically complicated children in foster care, really as a result of Medicaid coming to, at that point, the Children's Hospital and saying, you know, we're seeing a lot of kids that are really complicated and they're getting either duplicative services or they're not getting what they need and they're costing us a lot of money and what can you do to help, and the Department of Social Services seeing that a lot of medically complicated children were going into foster care and weren't getting the services that they need and they were either staying in the hospital waiting for foster care homes or they were going into one home and being there for six months, too much for the foster parent and transitioning.

So the goals of this program were to provide a one-stop shop for all health and social services, in many ways the way Mary has described the PACE program, using an interdisciplinary team, providing cost containment for Medicaid, and then also working with social services to come up with a more standardized payment for foster children which would allow them to stabilize in homes.

Also, the public-private partnerships with providers who served medically fragile children were important. There were a lot of programs out there and some of that was the duplicative services for children with a lot of different waiver programs. So the stakeholders all got together and really participated in the design of this program, and the stakeholders -- South Carolina has some different agencies. Not everything is ruled under Health and Human Services. So the IDEA program was administered actually by the Department of Health and Environmental Control. The Department of Disabilities and Special Needs has the home and community-based -- not the home and community-based waiver program, but rather the VENT waiver program was under them, so it was everybody coming together and saying, how can we best

serve this population.

The program is a one-stop shop and these are the services that are provided in the program. So everything that was included in the -- everything was included in the bundled rate but inpatient care, outpatient surgery, and emergency room. And all of these other services were delivered from one location and the primary care physician would authorize the subspecialty visits. They would be billed fee-for-service, as were dental and hospital care.

The reimbursement methodology, as I said, was a capitated payment, per member per month, no matter what the disability of the child was, same payment. So it was $2,259 per member per month. The beauty of the piece with the Department of Social Services involved was that they brought to the table the Title IV(e) money, and that Title IV(e) money, as many of you know, is broad-based money that can be used for education and training. But what that allowed the program to do was staff salaries. If the physical therapist or occupational therapist or speech therapist was teaching the parent a new technique to work with the child or even teaching the child something new, that Title IV(e) money could be used in a cost-based reimbursement methodology.

It also provided for some great training for the foster care parents in how to take care of special needs children. So if you were going to get a special needs child that had a g-tube, before that child went into your home, you came in for training, supplementing what was already done in the hospital and really learned how to take care of that child, and it really -- the fear factor about a special needs child going in your home really went away.

So the combination of those two payment methodologies, the per member per month reimbursement averaged almost $4,900 and the per member per month cost a little lower than that. Now, this wasn't the case -- certainly, it depended on what the child's diagnosis was, what those costs were for the child. But the beauty of this kind of capitated payment, just like PACE, really allows the provider to provide what the child needs and the provider bears risk. But the hospitals felt very strongly about coming in as a provider. This is a population that needed care and that it was a way to really individualize care plans.

The outcomes over 12 years -- one of the really great things that the South Carolina Department of Health and Human Services, the Medicaid agency, did from the beginning of this program was to put together a group that was a comparative analysis group in the fee-for-service system. So they put together a group of children with same or similar diagnoses in the fee-for-service system, and every year at the end of that particular fiscal year, they would compare the costs of those children, the fee-for-service system, with what the costs were of children enrolled in the medically fragile children's program and then also do an analysis of the kinds of care that was being received.

And so what that quality analysis and data collected showed was that the gaps, in fact, in care coordination were closed, clinical outcomes, great improvement. Interestingly enough -- it surprised us -- there was an increase in subspecialty care that the children got. Now, some of that was children in foster care got placed because of medical neglect, so they weren't getting that care previously. But also, then we had seen children previously who were really being managed by the subspecialist when they could easily be managed by a primary care physician. So they got more subspecialty care, and that sometimes is a criticism of managed care. Oh, you're not going to get the subspecialty care that you need. And what they got was appropriate subspecialty care.

A lot of unnecessary expenses were eliminated just because of the duplicity of services. Sometimes, there were meds that were prescribed that weren't needed, or, you know, even with a medically complicated population, in this kind of situation they really sort of, in quotes, got better, so in many cases didn't need as many meds as they were on when they came into the program, or they needed different meds.

Cut the length of hospital stay and prevented a lot of hospital readmissions. And on that, I will say I will speak to that day center part of the model. By having children in there on a frequent basis, having that interdisciplinary team in that one location, that one-stop shop, you really can prevent a lot. You can see what's happening with the child, and the parents come in to pick up the child so you see other family members.

So, for example, in flu season, not only did we give the flu shot to the child who was medically

complicated, we made it available and we paid for it for the entire family, because right there, you've done some prevention on the front end.

The family satisfaction rate was extremely high. The emergency room use decreased dramatically. This is really one of the statistics that we're most proud of, is that the adoption rate for special needs children in foster care when this program started in the State of South Carolina was less than five percent, and the adoption rate went up to 60 percent for those who were enrolled in medically fragile. So to provide those children with a family system and a home for life is so huge. You know, we asked parents why, in many cases, and it was that that system of care was in place. They weren't alone in this. And they also really felt empowered because they were trained on how to take care of the child and the program is very family-centered. We really believe that the person who knows that child best are the caregivers, are the family, much better than the medical team. These are the people that live with this child 24/7.

The cost containment piece certainly was realized. The Department of Social Services was reporting an average $60 a day cost savings. That was primarily -- well, it was a couple of reasons. One was the stabilization of placement in the home. The other piece of that was that, in many cases with really complicated children, the Department was having to pay private provider homes to place the children in, and now with the training and the partnership and the program, the training was able to be put in place with the Department of Social Service working with the medically fragile.

And then very significant cost containment and cost savings for the State Medicaid program, averaging $10,000 per year.

So -- and then you want to know, then what happened next? It sounds great. South Carolina Medicaid was so pleased with the program that they applied to the Robert Wood Johnson Foundation for some money to replicate the program and put together training manuals. There were lots of States coming to visit the program, really interested in looking at this program and how it could work for them. And the visits were Medicaid agencies from other States, sometimes social service, and sometimes other children's hospitals or other providers.

The Duke Endowment was really pleased with the data connection and analysis that was going together and felt that a standardized data collection system would be a good thing for those programs across the State and other programs as they replicated so you could very easily compare data. So the Duke Endowment provided a grant for that data collection system.

And then in 2006, South Carolina Medicaid said that there were some changes with CMS and they were no longer allowed to pay a bundled rate methodology. So this is kind of an interesting move now. You are going to see -- I am going to catch you up quickly from 2006, five years later -- what happened. So you are going to look at a couple different models.

So then what happened was some of the services that were in that bundled rate were taken out so that it would fit more into a prepaid ambulatory health plan model, and those particular services were billed fee-for-service. And then South Carolina also submitted an 1115 waiver request pretty much at that same time.

And then in 2008, South Carolina Medicaid said that because of what they were able to do with some other programs in the 1115, that they were no longer going to be paid the bundled rate -- or they wouldn't pay providers any more the bundled rate for the medically fragile and families were given three months' notice that the program was ending.

And then the program did end in South Carolina in 2009 as an all-inclusive care program. The Department of Social Services asked the providers -- and the reason in this situation that the providers are children's hospitals is that children's hospitals really are the place where medically complicated children go. Either they go there for subspecialty care, in some cases primary care, that's where they go to be hospitalized, working very much in tandem with community physicians and other community agencies. But the hospitals also were able to take the risk financially. They had to structure whether they could take the risk to be the provider.

So the program now has morphed into a medical home, basically back again where it started when it started as a demonstration project, as an all-inclusive care program for medically complicated children in

foster care. Now it's a medical home again for medically complicated children in foster care. So it's an interesting look.

Then, okay, then what happened? What does that look like, and what happened as a result of that? Well, back in the fee-for-service system, as you all know, and especially with the budget cuts that have happened with the States, now there are limits on therapy, limits on home care services and DME, so we're not in a system anymore where the provider had the checkbook and could say, okay, we see that you need this. We're going to write a check and buy it for you. Now we're back with those limitations, so in some cases, children are not getting the services or the DME that they need.

We're back with a lot more fragmented care. While there is some care coordination, it's not a one-stop shop anymore, so there's not that quick look at, oh, gee, what's happening, or, you know, you're coming in today and your little brother doesn't look too good and you don't look so good and what's going on at home that maybe we can stop, or in some cases with medically fragile, the physician would see the child, but then the pharmacist would see the child and catch something that the physician didn't catch, or it might be the child might be in physical therapy and they might want the physician to come in and take a look, and that's all gone because everybody's not in a one-stop shop anymore.

And parents are really telling us that they're overwhelmed. They're having to go to too many different places. The coordination of care isn't there. More missed appointments, just because they're overwhelmed, and we've also seen some med noncompliance as a result of that.

Unfortunately, the adoption rate is down again and the frequency of placements is back up. The Department of Social Services had a cost increase and the emergency room use has gone back up, as has hospitalization.

Sort of the end of this, I really don't want to end this on a down note. I mean, I think if you can take the emotion out, which is pretty hard, but to look at, you know, just over a period of time and a lot of what we've seen just changes in different administrations, what's happened, this is what's happened. I will say that children's hospitals around the country have really looked at this and looked at other programs and

looked at the ACOs and have done a very good job. Arkansas has got a new program for -- a medical home for medically complicated children. They are saving, on average, of about $1,200 a month and providing good quality of care. So those people are looking at models and what's the best way to take care of this population, and combining that with the children's hospitals, really looking at a way to improve quality of care at the same time.

So I think my presentation probably is more of a lessons learned presentation and is kind of quickly laying out to you some different ways of looking at that population.

Thank you for your time, and I look forward to taking questions.

CHAIR ROWLAND: Well, thank you, and thank you for providing us with the model that you had and also what can happen to a good model over time.

Questions from -- Mark.

COMMISSIONER HOYT: For Mary, maybe. You have been with the PACE program for such a long time in Wisconsin. I'm just wondering if there's some kind of critical mass size-wise for a PACE site. You're a pretty good size now and it seemed like you've experienced some efficiencies, the size you're at now. Is there some level that would be good for a PACE site to get past to operate most efficiently?

DR. GAVINSKI: Well, I think that getting to 300 is a really good place to be for just spreading some administrative cost. But I have to say, I think we are, with all of the changes going on, I think we need to grow and we need to know how to grow, or we need to grow a lot more PACE organizations to be able to meet the needs of all the duals out there.

So one of the things that has happened since we're now at 1,500 on our PACE side and on our partnership program we have about 570 is we've really been able to spread our administrative cost substantially more and that has really brought our administrative cost down significantly. One of the things we're talking about on a national level is how do we maybe work together to look at some of the back office functions and having smaller PACE organizations be able to buy that from larger organizations and maybe that's a way to do it.

But I think we were so focused on getting the model going and doing it in the right way and making sure that it was done in a quality way and then getting the regulations, which were all very important, but I think we're ready to take that next leap about being more relevant to -- and still maintaining, because I think you can do it. I really -- I'm seeing it on the family care side a little bit, although because we don't have that primary and acute care, that's not the model that I would propose as being the good model to do, but we still are able to provide a lot of services through having a medical director and some of our PACE organization learning that we can take to that program.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: I want to come back to Pat's example, but sort of go, you know, think about it in the broader context of the whole panel. So if I understand your case study, there is -- the thing that brought you down was the payment structure that was used, and this, I think, is an enormous issue for us.

In the case of adults -- and I would argue it's incorrect for adults, too -- in the case of adults, the focus has been on the integration of Medicare and Medicaid, which is, of course, terribly important. There are -- in the case of the under-65 population, there would be job training programs, there would be adult education programs, there would be social service programs. But this problem is particularly serious for children because so many of the services that are absolutely essential are established as educational programs, social service programs, child welfare programs, adoption assistance programs.

CMS, of course, went on an absolute tear between roughly 2003 and 2008 to absolutely stop what it characterized as a cost shift from these other programs onto Medicaid. I always felt that, in fact, they had no evidence that there was any cost shift going on. What is absolutely the case is that there was an overlap in allowable activities under multiple programs.

So, for example, I know from just having looked at it that in TennCare, the program for children with autism spectrum disorder, which TennCare pays for, is all about training parents to manage children with autism spectrum disorder, which, of course, in South Carolina would have come up as, it sounded like, child

welfare source of training.

Something absolutely has to be done, and I think we need to address this in our recommendations and our assessment about long-term care structures, to recognize that in a society in which the social conditions of health are so determinative of health care, that there will hopefully be overlapping programs and that it is perfectly appropriate as long as there's an accounting system so the two programs are not paying for the same activity. It is really up to a State, as far as I am concerned, whether to allocate the cost onto Title IV(e) or onto Title IV(b) or onto medical assistance. Obviously, for health care costs, the reason would be that the contribution rate would be higher. But for other services, health promotion services, there may be three or four pathways to a State. And I think that is fundamentally a question for the State, and then the issue for the Federal auditing process is to make sure that the Federal audit didn't pay twice.

Now, I may be alone in this. I would be interested, actually, in Mark's views about this. I think you know a tremendous amount about financing. But I do not understand why we would use rigid financing structures that prevent what is essentially a case payment model. This is a bundled case payment model that cuts across several different financing streams. Why it would be okay to pay capitation rates for this and not case payment rates, why it's okay to use a case payment if it's all Medicare-Medicaid financing but not if it's Medicaid financing with child welfare and social services thrown in.

I just -- I think that we are going to be hamstrung in moving out of this box we have created, especially for the child population, if we don't deal with this.

MS. VOTAVA: If I could make one comment on that Sara, that is the best description of what happened that I've ever heard, so, yes, that is exactly what happened.

[Laughter.]

MS. VOTAVA: So what we saw as a result of it -- now, the providers did have the option of, well, okay, so Medicaid's not going to pay this bundled rate anymore. You can keep providing the program if you want. Well, it was financially --

COMMISSIONER ROSENBAUM: Right. You can't. That's ridiculous.

MS. VOTAVA: -- completely unfeasible because in a fee-for-service system so much of what made that program a success, like the day health center or the other pieces that the hospital just said, you know, no, we know it's not included in the bundled rate, but this is the right thing to do, and this is what is needed and we're doing it, you know, no longer could be provided and paid for. And then that training money only was applied to -- you know, only applied if you had a foster care population. So depending upon what your census was, if your biological population really exceeded your foster care population, then you dropped down about what education and training money you were going to bring in. So I would completely -- that would be great, if you all can figure out a way to be able to put pots of money together to provide what's needed, please, go for it.

VICE CHAIR SUNDWALL: Thank you very much. This is really interesting, and as you know, this is such high priority for our Commission and the country. I really think it's very, very impressive.

I was, Aileen, very impressed with your not-for-profit yet profitable company that's interested in this. It's just refreshing to me to think that there are enterprises out there that are willing to help us tackle this, and I'd like to know more.

And, Mary, I visited On Lok in the early 1980s when I was working in the U.S. Senate as a staffer, and Marie-Louise Ansak was such an infectious, charismatic person, and so the model is very impressive.

My question, though, for you is -- and forgive me, it sounds too good to be true, meaning how on Earth do you cope with specialty services? This population must need surgeries, neurosurgeons, joint replacements, and how on Earth do you manage? When you say you do it all, it just makes me pause because as a clinician myself, I am a little skeptical. How do you do it?

DR. GAVINSKI: Well, I will tell you that I wondered that same thing when I started, and when I went in to talk to the dean and to the CEO, I said, "I am willing to do this," and I saw it being done at On Lok, and, of course, I believed it. But I said, "I know we can provide better quality of care. I know we'll be able to do that. But will we really be able to manage the acute-care costs? Or will the burden of the acute-care costs take away from some of the beauty of the rest of the things that need to be done?"

I also knew, though, that, you know, it was pretty easy for me to get someone into the hospital, and a lot of specialists, at least at that time, really didn't understand about cost-effective care. And people were going to multiple specialists and multiple primary care physicians and repeated hospitalizations. So I thought, well, if we can control it -- and I believe Cathy Eng and Marie-Louise that it could be done, you know, I'm all in.

I didn't sleep for the first month because I was on call, and I thought we're going to have one person end up on the ventilator for three months, and then we're going to go broke.

What I learned -- and the other thing is we had five people who, if you look at 100,000 covered lives, were in categories that they should have been our most expensive people from a cost perspective. None of those five people ended up being our most costly people over the course of the next five years. And, in fact, one of them lived for 11 years. I'm not quite sure how he actually did with how ill he was.

The reason it works is because Medicare and Medicaid pay appropriately. Now, they ratchet it down every year. I'm nervous about it every year. But with really good primary care and specialists who understand -- and I think it's easier actually now than it was before because now, you know, my colleagues understand that we have to be cost-effective, that we can't provide trade name drugs for every single thing if you have a generic drug that does the same thing. And it has worked. That's all I can tell you. It has worked. And do we make money every month? No. I mean, we've done transplants. We've had people on vents. I've got two people on chronic ventilator in nursing homes now and five people in their homes on ventilators. But the financing has worked.

But that's the thing that has to be the most concerned about the encounter-based Medicare financing that's coming down and how that's going to affect it, and also on the Medicaid side, I don't think we've got the financing for the younger disabled population quite worked out because the needs there are different. And it just is more costly to take care of people in their homes the way that they need to be taken care of.

MS. McCORMICK: In fact, I just want to maybe offer another comment to David on the issue of specialty care because primarily for us, because we're sort of just getting into the SNP business, our H-1

disabled non-duals are all Medicaid reimbursement levels. So talk about challenging reimbursement for physicians.

I think the reason we've been able to make it work is we look at the holistic cost of that member, so quite frankly, there are phenomenal specialists in like a Houston who are not interested perhaps in being part of a Medicaid panel, but they will on a single-case basis. So, you know, we're all about getting the right care at the right time and the right place. So it would be a little bit shortsighted to say, well, we'll just send them to -- you know, try to get the primary care guy to work it out when they really maybe need a very specific subspecialty. We'll pay more for it because at the end of the day if it minimizes unnecessary inpatient admissions, the entire cost of that member is still certainly less than in a fee-for-service environment.

COMMISSIONER SMITH: A comment and then a question. Patty, you had mentioned earlier that you have adults who check in and you can't seem to get them out for up to a year sometimes. I know it can happen on the other end, especially with children who need to go into foster care, that they can either be born with a disability, prematurity, or, you know, have been abused and end up with some type of damage, and then the hospital -- I know as a foster parent of medically fragile children -- can end up with a lot of these children basically living in the hospital. And I wanted to know from Pat, were any of the studies done on the medically fragile program, did they factor in the cost of no longer having the children basically warehoused in the hospitals for the first -- because they were able to get them out into foster homes?

MS. VOTAVA: Not specifically, I don't think, Robin. I mean, what happened once the program -- oh, sorry. I don't think specifically. One of the things that happened was when the program started, when that comparative analysis group sort of was the beginning point. So if there had been a child that came into medically fragile somewhere in that year, those hospital costs would have been there. But I think much more -- no, I don't think that was captured.

COMMISSIONER SMITH: Do you know if the hospital ever was able to determine if the medically

fragile program helped in that sense, they were able to get the children out?

MS. VOTAVA: Yes, absolutely. Yeah, I mean, and DSS could track that, too, because they knew how long children would be in the hospital waiting for homes. And one of the roles medically fragile took on was -- I mean, certainly we didn't agree. DSS would have loved it if we would have said we'll also help recruit foster parents, but that was too much for the hospital. But we did say, you know, that if you found people who were interested, we would provide the training. So we started training people who were interested in being foster care parents of special needs children so when a special needs child did present that had to go into foster care, there was a bank of parents that were already trained and who were willing to take those children.

COMMISSIONER SMITH: Just one more. Biological families, were you able to help them? Just my experience, I recall that often the hospital itself would be intimidating to some of the biological families. Maybe they had a child born that was premature and had retinopathy and could no longer see from, you know, a procedure or whatever. And just because the hospital was intimidating, they didn't bond or whatever and would end up having to go into foster care.

Did you see any advantage to having the medically fragile home for the biological families?

MS. VOTAVA: Yes, because one of the beauties of the program and the flexibility was that the staff could also go out to the biological family's home. So where the hospital might be a little intimidating -- I mean, and who really takes care of a child in that kind of environment, anyway? No one. You know, it's what your home looks like and how your home functions. So the staff could go to the home and either help adapt the home or help train in the home so the family was more comfortable, and they would also go into the school, and the teachers from the school would come into the medically fragile program, and sometimes they would even come in the summer so there was a great sort of holistic approach between community, school, home, the program, and then program staff could go into the schools and would go with parents even to IEPs. So it really kind of knitted everything together.

COMMISSIONER CHAMBERS: A quick comment and then a question, Mary, to you. As a

community that is developing a PACE program in our health plan and trying to develop a completely integrated acute- and long-term care system of care, including integration of Medicare and Medicaid services, I had the chance to come to Wisconsin last year to see what Community Care has gone through, and we hope to continue to work with you because the struggles you've had in trying on that path to full integration and expanding the PACE program, PACE without walls concept, younger, and those with Medicaid only is really -- my only regret was that I came to Milwaukee in January.

[Laughter.]

DR. GAVINSKI: Bad choice.

COMMISSIONER CHAMBERS: From Southern California, and when I got off the plane, it was like maybe I should go back. But, really, you guys have a model program in what you're trying to achieve, and I think this Commission certainly can learn a lot from what you've done.

But the question is really addressed to Aileen. When you look at a map of states with SNP programs, there's 41 states now that have a SNP program somewhere. So there's certainly -- there's states that don't have programs that try to coordinate across Medicare and Medicaid, and then you have parts of states that they might have one in an urban area. Any comment on how we can possibly get to places where managed care doesn't exist today to get a coordinated system of care?

MS. McCORMICK: Yes, that's a great question. I think making the -- reducing or lowering the barriers to entry for a SNP, our model is really around we follow our dual eligibles with a SNP. We don't start with the Medicare because we're really not interested in trying to be a pure play Medicare plan. We really are just trying to sort of go to the natural extension of our dual/non-dual program. So wherever we have ABD duals, we want to have a SNP, and the barriers to entry with some of the things I talked about earlier -- the network requirements, the sense that because we're not really like a Humana, right? We're not going to be 100,000 Medicare lives in any -- we'd like to be, I guess, over time. But I worry that, you know, there's just a prioritization in awarding business. And so I think we struggle a little bit with small numbers and how to get bigger faster, and then just the whole notion of we have a state, like Texas, for example,

places like El Paso, Lubbock, Jefferson which is Beaumont, those aren't super-urban environments, and the state is wanting to contractually obligate us to have a SNP as part of our Medicaid award in the most populated counties. And I think that's great, but without removing some of those barriers to entry, we sometimes struggle, even though we're very interested in getting there.

I think the auto enrollment or the passive enrollment would be another way to help with that as well.

COMMISSIONER CHAMBERS: Thank you. Just a general comment to the Commission, I think that's something we're going to have to struggle with, trying to look at models, alternative models where traditional models may not work, because the ultimate goal is to coordinate and integrate care across the spectrum, and there are going to be places where it's going to be very difficult to do that, and I think if we're going to get that to every beneficiary in the country somewhere, we're going to have to explore every model that's available. Thanks.

COMMISSIONER MARTINEZ ROGERS: I'm from Texas. I'm just wondering how the cut in Medicaid in our state affects your program, in particular in mental health, and the lack of more and more mental health services.

MS. McCORMICK: So behavioral health is integrated within the Star Plus program in Texas, which has been a good thing, and we have a psychiatric master's-prepared RN who sort of leads that charge statewide for us in terms of programs. We do a lot of partnering. We have some creative programs that I'd love to maybe get with you offline on. One is called Rising Star, which we've had tremendous success with. And we've actually sort of tested it because I tend to get worried about let's not rest on our laurels, what's the next innovative thing. And what we're being told by other behavioral health specialists is that's still pretty state of the art and keep on doing that program. So we're actually rolling it out statewide.

The cuts this last session were very significant. We felt it, as did every provider across the board, and so we're trying to be really innovative. We're doing a lot with provider collaboration. We're trying to get away from -- and, you know, these ladies are certainly more adept at this than I in terms of not using fee-for-service approaches, right? Paying a payment for every service, a transactional kind of relationship.

And we have had a lot of interest, more so than I expected, to be honest with you, with providers and some who integrate behavioral health within their primary care setting, who are interested in moving to this next wave of how we can help them transform their offices to be able to provide more services with less. And I think there's a lot of creative things that we're embarking on, particularly in the states where we are, and Texas is a good example of that, that will just help to address that.

You know, from the other standpoint, back to the issue of specialists, at the end of the day we're going to provide the services that are needed, and if that's going to cost us a little bit more than what that provider would have gotten on a fee-for-service basis, if it makes sense in the holistic caring of that member, we're going to do it. So it gives us flexibility because we are captitated, we are at risk, so we don't have to necessarily follow all of the same -- we can't get too far ahead because we're not funded to, but we do have flexibility to look at doing some creative things, and the provider community is who we're engaging with to help bring that to bear.

COMMISSIONER MARTINEZ ROGERS: One last question, and that is, you know, Texas is so spread out, and in terms of in the rural communities where there is in some areas no access, as I'm sure there are in other states, no access to Internet services, I assume that you're not in the rural areas, all the rural areas. Are you in South Texas?

MS. McCORMICK: No, ma'am. But March 1st we will be in all three regions of the rural service delivery area. So that does bring with it a whole new set of challenges, and we're trying to sort of get ahead of the curve in meeting with some telemedicine providers. We think there's a real opportunity to do more of that, and I think it's really -- there's not enough of it in Texas even available. And so we're hoping there might be ways we can partner with whether it's Texas Tech or UTMB to help provide some seed money, because at the end of the day, you know, we made a long-term commitment to be in the states that we're in. And so if there are things we can help do to advance some of these access problems, particularly in rural Texas, to your point, it's interesting, because my colleagues say, oh, you just have some expansion in Texas. They have no idea. You know, it's 11 hours for me to drive to El Paso, so it isn't just like adding another

market as it would be in New Jersey, for example.

COMMISSIONER COHEN: Aileen, I wanted to follow up with you on some of the discussion that we actually had with the earlier panel about housing. I assume you work in some areas where there is high-cost housing, and I'm assuming for some of your enrollees, housing is a real problem. They lose their housing, or they're in institutional care and they really could be living at home if they could afford a home. And I just wondered from a managed care perspective -- I understand -- I mean, there are so many barriers to the State and federal government kind of figuring out, even if everyone can acknowledge that it is, of course, less expensive and probably better quality to have somebody served in their home with supports than in an institution if they're capable of doing that. One of the promises of managed care is that because it's a private entity at risk, it could kind of address some of those issues in a way that's bureaucratically harder for, you know, the federal and state government to work out. One thing I know state governments struggle with is if somebody leaves a nursing home, that patient may be served less expensively when they're in their home, but then there's an empty nursing home bed, and probably somebody else is going to go into it. And so they may not really feel the cost savings in the same way.

So I'm curious from a managed care perspective when would it ever make sense for managed care to actually think about investing in housing? Do you ever do it under any circumstances? And if not, what are some of the barriers?

MS. McCORMICK: Yeah, it is a hugely topical thing, particularly with the work we do in reintegrating folks out of a nursing home. So we work a lot with Centers for Independent Living and different advocacy groups who are relocation specialists hired by the state. It's a very collaborative process, because we, interestingly enough -- and this would sort of surprise some folks. We have a shown track record of reducing the rate of admission to nursing homes. We don't have nursing home risk, but our model and our philosophy is about independent living and non-institutional bias. So we still want to get these folks onto our cost, right? I mean, some might be cynical and say, well, you just let them linger because you don't have that risk there. And we really have shown that we don't do that, which is one nice quality

metric that I like to talk about.

But the issue of housing is real. I was really happy to hear about this CMS-HUD partnership and whatever work they're doing there. We find it varies by market. There's one market in Texas where all the HUD vouchers go to the homeless, so we can't get their attention for folks we want to reintegrate out of a nursing home.

A lot of times we actually -- there's family, and so with the right home modifications, we can actually reintegrate back into an existing home. So that helps. But, honestly, we could have some folks on Money Follows the Person where we're working for six months to get them out, and the barrier is people are all working 90-0 trying to find affordable and accessible housing.

There's a couple of companies that I've met with recently that do some affordable housing communities. You know, it's real interesting to me to try to find some partnerships around that where it would work for the vendor. I mean, short of -- I think it would be cool for us to sort of as a side business, you know, get into the affordable housing market. But it is -- we're not, and we don't pay for housing. That would be -- maybe if we had nursing home risk, the dollars could work. But without it we --

DR. GAVINSKI: We actually have group homes and assisted living -

MS. McCORMICK: And we have that, too.

DR. GAVINSKI: -- because of the -- that we developed because of the inability to get people out of the nursing home in certain parts of the counties that we serve. So we were having a real problem with C level group homes because people come in nursing home-eligible already, and we are on the hook for the nursing home care. So it was just less expensive for us to develop that ourselves.

COMMISSIONER COHEN: You actually built the housing?

DR. GAVINSKI: Yes, and we're just about ready to build some more.

MS. McCORMICK: One of the things -- it is interesting because we don't own it, but assisted living facilities, when we moved into Fort Worth in February of this year, the rate of admission into nursing homes from assisted living was very high -- higher than what we see in any other market where there's less

dependence on assisted living facilities. So we've seen -- it's almost like low-hanging fruit. We've reintegrated more people in that one market year to date than we have across the rest of the State. It's a new program, right? So there was pent-up demand. But we do try to move them into more independent apartments, homes, back with family if available. And the Centers for Independent Living around the state do a fantastic job pulling out all the stops trying to help in support of that. So working with those advocacy communities is really our approach to trying to address that.

COMMISSIONER COHEN: Can I ask just one quick follow-up? Okay. Then I won't ask about [off microphone].

COMMISSIONER CARTE: I just wanted to ask Pat about her program when it was operating, and excuse me if I missed this. We're having such a great discussion, and I'm trying to absorb it all. But was there a minimum number that the program needed to operate with an economy of scale? And I'd also like to know if there was any waiting list or did you have a special outreach or case management effort to bring people --

MS. VOTAVA: You know, interestingly enough, the minimum number that it needed to operate even successfully financially was really small. When the first program started up, I think initially that enrollment was 20 children. When the first rural program started up, that initial enrollment was 12 to 15 children. Now, the key piece of that was, you know, that foster care piece of it, you got that Title IV-E money, and because what Medicaid was reimbursing on a PMPM wouldn't have been enough to cover it. So you really had to look at that pace.

COMMISSIONER CARTE: Thank you.

COMMISSIONER COHEN: I was just going to ask about -- sorry, and thanks very much for the earlier discussion. Obviously, when I asked my question, I didn't realize that you weren't at risk for nursing home care. And that's true in all the markets that you're in?

MS. McCORMICK: We do have nursing home risk in New Mexico, in Tennessee, so actually our preference would be to have it. It's a little bit of a lobbying issue.

COMMISSIONER COHEN: But where you have it -- again, I'm just sort of trying to get to what the barriers are, because I think where you do have it, why not the sideline business in housing development? Or why not looking at -- what other barriers -- and the barriers may be rules that won't allow you to do it, rules that will adjust your rate the next year because housing isn't a recognized cost. But I'm sort of trying to explore a little bit more what those are.

MS. McCORMICK: You know, it's a good question. I think we've not allowed it to be a barrier. We have never had someone we said, "We can't get you out of a nursing home because we just can't find affordable housing." That has never happened. And I think if that -- to us, right? For folks who we've assessed and qualify and are interested in coming out. It's just the amount of manpower and hours spent can be pretty Herculean. And so I think if it -- and at some point it could get to that, right? Where we start seeing that as a real barrier, where we don't find an option. And then I think we would have to start having those discussions more seriously with our state partners.

* CHAIR ROWLAND: Well, thank you all very much. I think this has been a very enlightened discussion. I think that even though Pat ended on a sadder note than a positive note, she gave us a great deal to think about in terms of what works for these fragile populations. I particularly like the fact that we had the diversity of different models for different parts of the high-need, complex populations, and so I think this has been a very fruitful discussion today.

Clearly, we've gone through looking at the fact that the complex populations we're talking about have many, many different features. Patty has reminded us that we can't just look at the long-term services and support side, but we have to look at what's pent-up on the medical side in some of our hospitals. We've looked at how to do integration as well as disintegration. We've looked at models, and we're going to have some experience now of trying to figure from an international perspective what we can learn about ways that go beyond the U.S. fragmentation to integration model.

We've learned to really also look at the fact that payment structures matter. I think that our access and payment responsibilities as a Commission came back around to circle and remind us that the two are so

intertwined that we have to make sure that we're looking at both sides. And I think as Richard warned us, we have to find alternatives to even some of the models that are there.

So it has been a fruitful discussion, and we appreciate both this panel and the last panel for helping to give us better evidence and information on which to develop our future reports and recommendations.

* So, with that, I'll adjourn this panel and ask if there are any public comments that the public would like to make before we conclude our meeting. If so please take the microphone and identify yourself and pose your comment or question.

[No response.]

CHAIR ROWLAND: Seeing no one at the microphone, I'm presuming that we can then adjourn this meeting of MACPAC. Thank you.

[Whereupon, at 12:26 p.m., the public portion of the meeting was adjourned.]