MACPAC

Medicaid and CHIP Payment and Access Commission

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

Thursday, November 17, 2011
1:09 p.m.

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

LU ZAWISTOWICH, ScD, Executive Director

DAY ONE AGENDA ..... PAGE

Session 1: Discussion of MACPAC research and analytic agenda

Diane Rowland, ScD, Chair 4

Session 2: Provider participation in Medicaid

Lois Simon, Principal Analyst 7
Anna Sommers, PhD, Senior Health Researcher,
Center for Studying Health System Change 8

Commissioner Discussion Lead: Judy Moore
Staff Contact: Lois Simon, Principal Analyst

Session 3: Children and pregnant women in Medicaid and CHIP

Chris Peterson, Director, Eligibility, Benefits and Enrollment 36

Commissioner Discussion Lead: Herman Gray
Staff Contact: Chris Peterson, Director, Eligibility, Benefits and Enrollment

Session 4: Promoting Medicaid program integrity

Caroline Haarmann, Senior Analyst 60

Angela Brice-Smith, Director, Medicaid Integrity Group,
Center for Program Integrity, Centers for Medicare and Medicaid Services (CMS) 62

William A. Hazel, Jr., MD, Secretary of Health & Human Resources,
Commonwealth of Virginia 68

Lloyd S. Early, III, Special Agent-In-Charge - Health Care Fraud Section,
Office of the Ohio Attorney General 74

Commissioner Discussion Lead: Trish Riley
Staff Contact: Caroline Haarmann, Senior Analyst

Meeting discussion and wrap-up
Diane Rowland, ScD, Chair 103

Public Comment 104

Adjourn 106

DAY TWO AGENDA ..... PAGE

Session 5: Basics of Medicaid financing

Jim Teisl, Senior Analyst 108

Commissioner Discussion Lead: Andi Cohen
Staff contact: Jim Teisl, Senior Analyst

Session 6: Payment and financing issues in Medicaid managed care expansion

Billy Millwee, Medicaid Director, Texas Health and Human Services Commission 120

Rob Damler, Principal, Consulting Actuary, Milliman 128

Commissioner Discussion Lead: Richard Chambers
Staff contact: Jim Teisl, Senior Analyst

Session 7: Lessons learned in serving certain high-cost high need Medicaid populations in managed care

Christie Peters, Principal Analyst 148

Darin Gordon, Director, TennCare; Deputy Commissioner,
Tennessee Department of Finance and Administration 151

Patti Killingsworth, Chief, Long-Term Care, TennCare 166

Commissioner Discussion Lead: Donna Checkett
Staff Contact: Christie Peters, Principal Analyst

Meeting discussion wrap-up
Diane Rowland, ScD, Chair 195

Public Comment 195

Adjourn 196

P R O C E E D I N G S [1:09 p.m.]

CHAIR ROWLAND: Okay. If we can get ready to reconvene, that would be great.

[Pause.]

DISCUSSION OF MACPAC'S RESEARCH AND ANALYTIC AGENDA

* CHAIR ROWLAND: Welcome to this meeting of the Medicaid and CHIP Payment and Access Commission. This is our November meeting to really review where we are going to be going with regard to our work toward this March for our March report and then later for our June report. It's a meeting in which we will be discussing a range of issues that we will be looking at as the key components of our March report. And this is the meeting where we have also begun and want to continue our discussion of our research basis and our analytic priorities so that we can highlight the policy work we're doing in several key Medicaid and CHIP topic areas that are underway, and these will provide the basic components of our report in March.

We also are mindful of the fact that as MACPAC we are charged with a broad set of responsibilities that will probably go well beyond the scope of what we're able to accomplish and review between now and our March report, and so we'll be looking at laying out the groundwork for our work over the next few years.

We now have passed our one-year mark, so we are no longer a first-year start-up. We are now entering our second year of operation, and I am pleased to report that the Commission members have come together and coalesced very well as a Commission, and we have a terrific staff that is providing us with great insight and support on the work that we're trying to do.

Some of the key points that we've been working on as we're structuring our analytic plan are on

activities that we think will help us to be able to give some advice and counsel and data to the Congress on some of the key policy questions that they're deliberating on right now and some of their framework to begin develop some of the quantitative and qualitative analytic projects that will help move in new directions around care for people with disabilities, around the future of the CHIP program, around looking at how managed care is evolving as a mechanism for the delivery of services within the program. And we conduct these public meeting sessions so that we can review with you the work that's underway so you can see the kinds of analysis that we are commissioning to help shape our opinions and also hopefully during the end of the meetings to get some input from the public on what you think our priorities should be on what some of the issues you would like to see us address are.

We're going to begin today to really start laying the groundwork for the March report that will focus on the characteristics of Medicaid enrollees with disabilities. We're going to be looking at several topics relating to paying for value in Medicaid, such as payment processes, financing, program integrity, access, and quality. You're going to hear from a range of speakers that we've invited in to provide us with some better in-depth knowledge of what's going on on the ground. We're going to be looking at the children served by Medicaid and CHIP, including children with disabilities, and trying to really shape how the policy around those issues is being developed and where some of the challenges in the future are, and then begin to lay down the longer-term plans for MACPAC's multi-year research agenda.

What we want to have the Commission focus on is to discuss our research and analytic agenda to begin to look at how we're going to put together these reports for March and then later for June, and then how to go beyond that. And we're really pleased that we can start with a session that I think is very important in being able to look at access and quality in Medicaid. And so as we move forward, this is really

a critical time for us to shape our agenda, and before we turn to our first panel, I wanted to ask our Vice Chair, David Sundwall, if he wanted to offer his welcoming comments as well.

VICE CHAIR SUNDWALL: Well, thank you, Diane, and yes, I do just want to welcome the public here. We are pleased to have you join us for this meeting. We do, as Diane said, feel a bit more mature now. We've got our feet on the ground. We know each other and are working well together.

As you know, this is an absolutely nonpartisan group that is intended to give good data to the Congress and hopefully help in the process HHS and CMS and state Medicaid directors as well. I think that we have demonstrated we have the capacity and the brain power in our staff, thank heavens, to come up with some very useful data and some reports.

I will just say that, from my perspective out in the state, it's just astonishing how Medicaid is in the cross hairs that I feel as someone who has advocate for Medicaid in a conservative state that it is beleaguered and has kind of become the poster child of what's wrong with big bad government. While there's some basis for that concern, we all know that they serve an important constituency in our country.

So to the extent that we as a Commission and others can identify how Medicaid serves as a safety net in our country, that's an important responsibility of ours. So I think our deliberations are timely and important, and I look forward to hearing from the panels today.

Thank you.

CHAIR ROWLAND: And so today we're going to be discussing the children CHIP and pregnant women issues. We're going to be discussing quality and access, program integrity, and we're going to start our discussion actually by focusing on some of the issues related to access and quality in the Medicaid program, and I'm going to turn to Lois Simon to kick off this discussion. And I'm going to remind the

Commission members that under Tab 2 you have the materials related to this session, including the draft outline that we will be using if we go forward with this as one of the components of our report. So we're going to start with this discussion and end, I hope, with your comments on the outline.

Lois?

PROVIDER PARTICIPATION IN MEDICAID

* MS. SIMON: Thank you, Diane. Good afternoon. As you know, MACPAC is charged with examining access to care and services for Medicaid and CHIP enrollees. In our March 2011 report to the Congress, we presented a framework that was created to provide a foundation for MACPAC's analytic work for monitoring and evaluating access to care. The framework, which is intended to evolve over time, is comprised of the elements listed above. Our ongoing analysis of access will incorporate these components. Two of the elements -- provider participation and quality of care -- will be the focus of today's session.

CHAIR ROWLAND: Just for the Commission members, the slides are also in your book under Tab 2, if you go beyond the initial page.

MS. SIMON: Our June 2011 report to the Congress focused on the evolution of managed care in Medicaid. In the access section of the report, we reviewed how comprehensive risk-based managed care relates to each of the dimensions in the access framework. With regard to today's topics, states must meet certain federal requirements for monitoring both provider participation and quality, though in both areas states have a fair amount of flexibility in how they structure their programs.

The June report discussed how states use their contracts with managed care plans to improve access to services and measure quality of performance. With regard to provider participation, contracts with

plans can require compliance with standards for network adequacy. With regard to quality, states can make plans accountable for providing quality by requiring plans to incorporate quality tools into their programs.

To advance our work in the area of provider participation, you will hear today from Anna Sommers from the Center for Studying Health System Change. Anna is going to be sharing findings from a study on PCP willingness to accept new Medicaid patients. She will be followed by Jennifer Tracy of MACPAC who will provide an update on the Commission's 2011-12 quality agenda. I will turn it over to Anna.

DR. SOMMERS: Thank you, Lois.

CHAIR ROWLAND: Thank you, Anna, and welcome.

* DR. SOMMERS: Thanks. Can everyone hear me all right?

Thanks for the opportunity to speak before you today. Just to get started, to give proper credit -- let's see, if I go backwards -- no, I don't. I'd just to acknowledge that the study was conducted in partnership with the Kaiser Family Foundation Commission on Medicaid and the Uninsured, and the full report is available on their website at kff.org.

As a little background, two provisions, as you well know, in the ACA may impact primary care physicians' participation in Medicaid. The first provision extends Medicaid eligibility up to 133 percent of the federal poverty level, and this change is expected to attract about 16 million people to the program in the first five years, mostly non-elderly adults and mostly people previously uninsured. And it's anticipated that the health profile of the newly eligibles will differ from the traditional Medicaid population. And the market impact of such a large expansion could have a greater effect on how physicians view Medicaid than factors considered important today.

The second provision will raise Medicaid reimbursement rates for primary care services from

primary care providers up to Medicare levels, but higher rates will not apply to specialists, and the provision expires after two years. The intent, of course, of this bump in rates was to convince more physicians to participate in Medicaid. But we know from prior research that physicians' participation in Medicaid depends on many factors, not just payment. So retaining them over the long run will depend on these factors as well.

The design of policies to expand the primary care workforce in Medicaid and assure access to care can so be informed by better information about why physicians limit their participation and about the resources already available to primary care physicians who are willing to see new Medicaid patients.

The study objective was to describe willingness and resources of primary care physicians to accept new Medicaid patients. The study draws from a nationally representative survey and in-depth interviews with physicians. The survey data was taken from the 2008 Center for Studying Health System Change Health Tracking Physicians Survey. We analyzed a sample of primary care physicians, PCPs, excluding pediatricians, who work in direct patient care and not on hospital staff or in emergency rooms.

We also conducted in-depth interviews with 15 PCPs in the summer of 2010 after the health reform law was enacted. We recruited physicians from practices of different size, type, and region, and respondents included physicians reporting high, medium, and low shares of practice revenue from Medicaid.

The purpose of these interviews was to better understand how physicians make decisions to limit their Medicaid panels and how they anticipated responding to the Medicaid expansion.

This pie chart shows how primary care physicians in 2008 were distributed based on their participation level in Medicaid. We grouped physicians using two measures: the percentage of practice revenue they reported was from Medicaid and whether at the time of the survey they reported accepting any

new Medicaid patients.

The physicians we call high-share Medicaid, the top slice -- and I'll go clockwise around -- receive a disproportionate amount of revenue from Medicaid, over 25 percent, compared to their peers. They make up just 19 percent of the population.

The moderate-share Medicaid physicians receive a medium share of Medicaid revenue relative to their peers, between 6 and 25 percent, and they also accept new Medicaid patients.

The high-share Medicare physicians demonstrated three characteristics that suggest potential for a response to an increase in Medicaid payment up to Medicare payment levels. First, they demonstrated a willingness to practice heavily in the Medicare market based on their share of practice revenue and acceptance of new Medicare patients and reported small, non-zero percentages of revenue from Medicaid.

Remaining physicians, a residual category that make up fully one-third of the PCP supply, fell into this low- and no-share Medicaid group. Relative to their peers, this group was skewed toward seeing private patients and away from public patients.

These four groups are distinctly different in terms of their willingness to accept new Medicaid patients. Based on the 2008 survey, a large majority of high-share Medicaid physicians, 84 percent, accepted all or most new Medicaid patients. Moderate-share Medicaid physicians are most similar to the high-share Medicaid group in that a majority accept all or most new Medicaid patients. Yet about one-third accepted just some and did limit their panels.

The remaining two groups are much less likely to accept new Medicaid patients. Only 20 percent of high-share Medicare physicians accepted all or most new Medicaid patients, and more than half accepted none. Among the low- and no-share Medicaid group, 80 percent accepted no new Medicaid patients and

about 60 percent reported no Medicaid revenue. This group seems to be the least likely to be swayed by policies to attract physicians to serve Medicaid patients.

So there are four key findings from this analysis that I will convey to you today, and I'm happy to elaborate further during Q&A.

The first two findings relate to these high-share Medicaid physicians that disproportionately serve those patients. We found that they have resources comparable to other physicians who serve fewer or no Medicaid patients and on certain measures have more resources than other physicians that would benefit Medicaid patients. For example, their use of health information technology supports are just as high or comparable to their peers. Fully three-quarters reported using all electronic medical records in 2008 and used health IT in other ways to assist in patient care, such as up-to-date decision support.

More of them also had institutional resources that provide important supports. More were owned by a hospital, 29 percent, or practice in community health centers, 18 percent; and fewer practiced in very small solo/two-physician practices, 26 percent, relative to their peers.

A majority also have in place important patient supports available at their practices, such as interpreters, 69 percent, and non-physician staff who provide patient education, 56 percent, that benefit subpopulations with complex needs.

The second finding also relates to this group. They appear to be willing to see more Medicaid patients and are well situated to do so, but face important limits on expanding capacity to treat more Medicaid patients. They tend to be located in low- to moderate-income areas where newly Medicaid eligibles will reside in large numbers, more so than other physicians.

When asked in our in-depth interviews, these physicians expressed willingness to take on more

Medicaid patients after the 2014 expansion, and some even reports having short-term capacity to see more Medicaid patients.

Now, two explanations for this could be the reduced utilization of physician services during the recession when these interviews took place and the fact that the same practices also serve the uninsured and expect that many of these patients will enroll in Medicaid. So they expect changes in how they are paid after 2014, but not all of them expect a surge in the number of patients.

But, in contrast, they also expressed concern about increased patient wait times, inadequate time with patients, lack of qualified specialists in the area, and difficulty finding specialists to see their Medicaid patients.

Finding number 3: In addition to these 19 percent that serve a high share of Medicaid patients I just discussed, about half of primary care physicians serve some Medicaid patients, but are significantly less willing to expand their participation in Medicaid. Just under one-third of the PCP supply is a moderate-share Medicaid PCP. There are advantages to targeting policies to this group that encourage acceptance of more Medicaid patients. They share many of the same desirable qualities and practice characteristics as high-share Medicaid physicians and also practice in low- to moderate-income areas.

Now, another 19 percent of physicians serve Medicare patients disproportionately, these high-share Medicare peers, but they see few or no new Medicaid patients. The practice characteristics of these physicians indicate what I would call a lack of fit with the newly eligible Medicaid population. They practice in distinctly higher-income zip codes farther from Medicaid patients. They have fewer practice resources in place like non-physician staff, and a larger share of them, 44 percent, are in solo/two-physician practices.

Finding number 4: Physicians who limit their participation in Medicaid and see only some or a few Medicaid patients report reasons for lack of participation in Medicaid that point to specific policies that require attention. While the majority of physicians who accept only some or no new Medicaid patients reported inadequate reimbursement as an important reason for their decision, the vast majority also reported other reasons, too, that were just as important. In in-depth interviews, the most often cited reason was the time-intensive burden and difficulty of finding specialists for their Medicaid patients. In the survey, delayed reimbursement, billing and paperwork requirements, and the high clinical burden of Medicaid patients were all cited by the large majority.

These same PCPs in in-depth interviews said that they expected that they or their practice leadership would revisit their Medicaid participation levels in 2014, but expected also that changes would be incremental, for instance, raising their cap on Medicaid patients from 20 to 25 percent of the patient panel.

Their decisions would depend on several factors: the illness burden of new patients, the changes in the private and Medicare markets, not just payment levels in Medicaid. Moreover, decisionmakers and factors they consider may differ from high-share Medicaid physicians because their practice settings differ, importantly that more of them are likely to be in group practices and fewer in community health centers.

So let us move on to the policy implications. The study results suggest that policymakers could use a two-pronged strategy to increase capacity to serve a wider population in Medicaid:

First, focus attention on the practices that already serve Medicaid patients disproportionately. Rewards for efficiency, improved access, and quality could lead to increases in capacity for Medicaid as these practices are well positioned and willing to see these patients. Several policy levers could be leveraged: patient-centered medical home initiatives by expanding after-hours access and post-discharge care

coordination; network adequacy requirements for managed care that require measuring unmet demand for care and strategies to address it; and incentives for private sector investment in telehealth which could lead to expanding networks of specialists accessible to Medicaid patients, helping to address PCP concerns about inadequate specialty referral networks for their patients.

Second, enlarge the primary care workforce serving Medicaid. This can be done several ways, but some obvious ones are reducing the administrative burdens physicians face to attract physicians to the program, but also by promoting the use of nurse practitioners and physician assistants in primary care.

Before I close, I would like to acknowledge and thank my co-authors, Julia Paradise of the Kaiser Commission on Medicaid and the Uninsured, who I think is in the room today, and Carolyn Miller, and the link to the full report is on this slide.

Thank you and I welcome your comments.

CHAIR ROWLAND: Thank you, Anna. I think that that this is an important contribution to our deliberations because it actually shows that the theory of just providing a bump in provider reimbursement is not a magic solution to how to get broader participation and access to primary care services, and I welcome the comments and discussion of the Commission members.

COMMISSIONER ROSENBAUM: I wonder -- and this is a question for any of the three of you, but also actually a question that maybe Donna or Richard might have some insight on. Do we really know whether Medicaid is a more burdensome insurer for providers than other payers? For example, I've actually been told by some physicians and pharmacists that Medicaid is quite an efficient and rapid payer. And so I'm wondering whether we really know anything about the payment burden, and I thought maybe Richard or Donna might know because you've seen plan administration across sponsors, and so you might

have some feel for whether, in fact, Medicaid makes it harder for a provider to get paid in a timely -- putting aside the payment level, but just, you know, timely payment of a claim.

COMMISSIONER CHECKETT: I think it really varies state by state depending on how the state's MMIS system is running, and states that have really out-of-date MMIS systems that are paying with lots of codes and edits that are deliberately set up to stop a payment and make the claim be readjudicated for the first error or the second error. But I think the other -- so the answer is obviously it varies, but also one of the administrative burdens that I hear about is in states with managed Medicaid, the provider has gone from having fee-for-service, which at least it was just fee-for-service, and now they've got contracting with three or four managed care plans, and they have different formularies and prior auth. processes and billing processes, and so that magnifies it. That would be my --

COMMISSIONER ROSENBAUM: But that's really a lot different from the private market today.

COMMISSIONER CHECKETT: Right.

COMMISSIONER ROSENBAUM: With physicians having to deal with 20 different plans.

COMMISSIONER CHECKETT: Right. And some claims also -- pharmacy claims in general pay very, very quickly because everybody is billing off that NDC code. Very different. My observation.

COMMISSIONER CHAMBERS: I'll just add from one plan, one part of one state, that's probably the number one thing I hear when I go out and talk to providers, is the administrative burden. But then when you ask them to really break it down, it is kind of hard to quantify. For instance, our state contract requires payment within 30 days, and our average is 14 the way we pay. We pay nursing homes weekly electronically. I think sometimes it's a smoke screen on some other things that providers say about their administrative burden.

I think the number one thing, though, is state contracts, the stuff that the state requires. They're always complaining about contracting burdens. The contracts are usually half an inch thick for a primary care physician, but, unfortunately, that's what the state requires.

So those are the kinds of things I hear, but some of it I don't think is always totally justified in complaints about Medicaid.

COMMISSIONER EDELSTEIN: Building on Richard's observation, I can share that review of studies of dentists with regard to their attitudes towards Medicaid and administrative burden, while Donna is right, it varies from state to state, the perception does not vary from state to state. So the states where there are facile, brief paperwork requirements, the dentists are as likely to say that the administrative burden is a problem as in states where it truly is. So I think it's a significant provider perception.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I have a number of questions and comments. Where you said hospital-based physicians were excluded --

DR. SOMMERS: No, no, I didn't say they were excluded. They were included. I'm sorry. Those that work on hospital staff in an inpatient environment. But physicians that practice primarily in outpatient settings at hospitals are --

COMMISSIONER GABOW: -- are still paid for by hospitals --

DR. SOMMERS: Yes, they could have been paid for by the hospital, had a fixed salary, but they had to work in the outpatient setting, not inpatient, primarily.

COMMISSIONER GABOW: Okay. And it seems like, really, when you look at your pie chart and the data, you said there are probably 25 percent of physicians who are really high Medicaid --

DR. SOMMERS: Yes. I think that statistic was 19 percent, yes.

DR. GAYNOR: Yes, but then when you take 20 percent of the 24 that really have a high volume of Medicaid --

DR. SOMMERS: Yes.

COMMISSIONER GABOW: -- you are probably at 25 percent overall. Do you have a sense of what percentage of that group are in community health centers and safety net hospitals? You really didn't discuss safety net hospitals specifically. My guess is that an overwhelming majority of that 25 percent would be either safety net providers or community health centers. I couldn't find that in the paper --

DR. SOMMERS: Oh, yes. I mean, we did not break them out by safety net or nonprofit, for profit. The types of practice characteristics included the size of a group practice, if they are in a group practice, whether it was a group or staff model, HMO, hospital-based practice, and then community health clinic, which is the only one that we really can draw off of, and 18 percent of the high Medicaid physicians were in community health centers and only four percent of the moderate Medicaid were. They were much more likely to be in group practices.

COMMISSIONER GABOW: Well, I would put forth a hypothesis that the overwhelming majority of high Medicaid are in safety net and CHCs and that would bring you to a somewhat different recommendation, I think, about a solution, which might be that rather than dribble and drabble dollars out to providers in onesies and twosies, that expanding the capacity of primary care clinics and the safety nets and CHCs would be a very effective way to go.

I would just make two other comments. Also, the –

CHAIR ROWLAND: Let me just ask, Anna, is there a way that you can run that data to separate

out the safety net hospitals?

DR. SOMMERS: I don't think so. We don't ask whether they work for a public hospital or government-run hospital versus, you know -- or nonprofit versus for profit.

CHAIR ROWLAND: Okay. So --

COMMISSIONER GABOW: I would just tell you that we are safety net and we have 65 percent of Denver's Medicaid patients in our system, so I would presume that is not an aberrancy.

The other thing I would say about the safety net is this issue about special access to specialty care, which 30 percent of your people mentioned as a barrier to take Medicaid, is, I think, really underestimated in all the zeal to expand primary care, which no one is against primary care, but I think the frustration about specialty care really shouldn't be underestimated, and one of the beauties of the safety net is it is the only place where, generally speaking, Medicaid patients can get special access to specialty care. So I think somewhere in the recommendation that piece also needs to be in.

And the other thing that people commented about was the complexity of the patients, and just as a comment, we were recently in a meeting with potential Medicaid providers in Denver who said they would be glad to take Medicaid patients as long as they spoke English and did not have chronic mental illness.

So I just think that also needs to be underscored, because -- and gets you back to the recommendation of structured systems of care like community health centers and safety nets, because small practices, even if they will accept some, don't have the resources to put these other wrap-around services that become so critical to providers not being so frustrated that they can't deliver the care they need that they get out of this arena.

The last comment I would make is that should you ever want to do this again, the study, the

percentage of the physicians who take uninsured, what percent of their patients are uninsured is another surrogate for their willingness in the future to take more Medicaid, because that is the patients who are going to be paid for in the future. They do have unique issues, which gets back to the previous point --

DR. SOMMERS: Yes. We do have that in the data. I am not sure if it is in the table in the report, but --

DR. GAYNOR: I didn't see it.

DR. SOMMERS: I can send that along.

I just want to point out, a couple of interesting things came up in the in-depth interviews that I didn't anticipate. One is that there are some physicians -- one we talked to is a solo practitioner in the South who primarily worked on a cash basis and he knew that a lot of his physicians were Medicare patients, but he just took cash. And in talking with him about it, I think he probably took a lot of Medicaid patients, but just took cash.

And similarly, if physicians are heavily treating the Medicare population, they're probably treating duals, but they don't know because Medicare is covering the physician visit.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: Hi, Anna. Good to see you. I just wanted to follow up a little bit, because I think the conclusion that it is not just payment, we might want to pause, because when you look at these findings on Slide 5 that you guys are just talking about, 43 percent of the high Medicaid enrollees are in hospital-based practices of community health centers. Therefore, they are probably getting higher rates of reimbursement. Those are the same providers that States say, ooh, we have to pay them costs. So I think we do need to sort of get a better handle on who those hospital-based providers are and how

many of them are getting costs or how those rates compare to other physicians, because, in fact, maybe rates have a bigger role to play here than we thought.

CHAIR ROWLAND: Okay. Mark.

COMMISSIONER HOYT: Yes. Geography was mentioned as a key factor in this, I am sure not the only factor. I was wondering, has anybody really looked or made a guess as to where the 16 million people are, because I am wondering -- this is a gross oversimplification, but higher income might mean there are going to be more Medicaid recipients in the future out in the suburbs or in different places that are closer to some of the doctors' offices that don't see people now. Income tends to correlate with higher education, maybe better access to transportation. Maybe there will be some pent up demand, but ultimately usually a little bit better health characteristics, i.e., lower risk. So I was wondering if we could get some kind of lift possibly from where the 16 million people are --

DR. SOMMERS: I think Diane wants to answer this question.

CHAIR ROWLAND: There have been looks at where the 16 million are coming from. I mean, remember, the statutory level is 133 percent of poverty and about half of many of those will be below 50 percent of poverty. So a lot of the new eligibles to Medicaid will be coming from the very same medically underserved areas that the current population comes from. So I think some of the issues with regard to who practices in the medically underserved areas where the community health centers are located remain very important for both the new eligibles as well as the old. But, certainly, the Commission can provide you with some background on that at our next meeting.

Richard, you are next up.

COMMISSIONER CHAMBERS: A couple of questions. On the policy implications, you

mentioned telehealth a couple times. You hear over and over again as State reimbursement policies are going to drive that -- did you hear any of that, you know, saying that was your recommendation, I don't know if you heard directly from your survey, or do you have any recommendations as to is that an issue that needs to --

DR. SOMMERS: No, we didn't talk about that issue with the physicians we interviewed and it was not present on the survey. But we know that primary care physicians and all physicians are terribly maldistributed and what telehealth can do is offset or help to balance out that maldistribution and make available to people in your rural areas the physicians that are highly concentrated and the academic medical centers in urban areas, and that is certainly playing out in California with some of the initiatives that have been going on the last few years there.

COMMISSIONER CHAMBERS: Yes. The e-Consult, which has been something that has been piloted in L.A. County and Orange County, that actually has great hopes for that program and its expansion. The problem is usually the physician, the specialist reimbursement, and that is a California issue specifically, but it is probably the biggest barrier for further expansion.

Another thing, another question is sort of the general category of administrative burden, and on one of your findings, number four, it talked about high clinical burden. Did you hear -- I hear complaints a lot of times from physicians' offices that it is the high needs of the Medicaid population and it is not medical needs necessarily, it is the social services needs, and they end up being needing the higher, almost, social workers to help do the connections, or the office has to use clinical staff to do non-clinical activities.

And so what I hear is, particularly in managed care, is where can the plan be the glue that sort of pulls those together, and it is like if we can sort of warm hand off to you when we get to the place where we

need it, we would actually be able to be more efficient and do things like that, and I am just curious if you heard any of that from other places in the survey.

DR. SOMMERS: Yes. In the in-depth interviews, we really probed that, and the responses were really all over the place in terms of what kind of clinical burden they were talking about. Some of them were talking about the high prevalence of mental health and drug abuse they brought up. But others were simply talking about chronic conditions or the time burden required to get on the phone and try to find a specialist for somebody with a complex need that really needed a referral. They said, we could take two hours trying to find a specialist and maybe fail and none of that time of mine is reimbursed. So it was a variety of things.

On the other hand, I do want to mention that there were some physicians who said, look, my Medicare patients are far more of a burden than my Medicaid patients. If the new Medicaid patients that walked into my office were like the young, healthy women that I get, I would have no problem bumping up my patient panel. But there is a lot of uncertainty about what to expect in terms of who would walk through that door.

And possibly, you know, a lot of States already do some risk adjustment in their payments, and so some measure of work there by States and managed care plans to assure doctors that, at some level that their payments will be risk adjusted could help alleviate those concerns.

COMMISSIONER CHAMBERS: Thanks.

COMMISSIONER EDELSTEIN: Hi, Anna.

DR. SOMMERS: Hi, Burt.

COMMISSIONER EDELSTEIN: Nice to see you. I appreciate that this study was generated

because of the new population coming in and that no researcher likes to extrapolate beyond the bounds of their study, but I would like to ask you to do so anyway.

Since half the population in Medicaid is kids and this didn't focus on kids, didn't include the pediatricians, and since this specialist issue and the dentist issue remains such thorny problems, can you, based on your general knowledge and other work you have done and this study, give us some sense of your impression about willingness of providers with regards to children, the specialists with regards to any age population, and then the dentists?

DR. SOMMERS: So we were focusing on the physicians that we expected would be serving the adult population, given that the expansion is mostly to adults. So I can't speak to that from this survey.

There has been several studies done on the problems with specialty referral networks, both for children and for adults. Some of the same specialties come up in those surveys. Orthopedics, psychiatry, dermatology, neurology are commonly reported as problems. But there is also a lot of variability in which specialties are a problem and by State and area, and some of that has to do just with the shortage of specialists generally. So in Western and Southern States where it is difficult to find an endocrinologist, it is even worse for the Medicaid population.

COMMISSIONER EDELSTEIN: But with regard to payment, any impression as to how payment plays in perhaps differently or the same with regards to children and the specialists?

DR. SOMMERS: Sure. What I can say in looking back over the history of fee increases since probably 1990 is that they have primarily focused on primary care. A lot of those increases are targeting primary care, not specialty care. And in some periods, the growth of physician fees for primary care has actually been faster than for Medicare. So the gap has closed a bit. I am not entirely sure what happened

over the past very, very recent, recently. And so, yes, I think that there has been less of a focus on specialists.

But I think that, again, I think there is very little information out there about how different States are approaching payment and I think that there are States that recognize that this is a problem and they can easily selectively target reimbursement rates to help.

And certainly, Western States, the Western Mountain States where the supply of specialists is very low, they have already raised their Medicaid reimbursement rates up to Medicare because it is such a problem. And those are also the places where there are going to be huge increases in newly eligibles. So the bump in reimbursement rates in the ACA isn't really going to have an impact there.

Sorry I can't say more to address -- I know you wanted me to talk -- I can't really talk about kids.

COMMISSIONER EDELSTEIN: Okay. And how well did those increases in the Western States work in terms of responsive primary providers?

DR. SOMMERS: So it's kind of a mixed bag. There certainly are correlations. I think, generally, the take-away point from the research is that it is the rate of acceptance of Medicaid patients that has the biggest impact. So it is a matter of how much those physician fees impacted acceptance of Medicaid patients, and the impact of physician fees on access to care for Medicaid patients is more indirect, and that's simply because there are a lot of factors that affect acceptance of Medicaid patients. So all of the studies point to other issues that could be addressed and need to be addressed.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Following up on Patty's previous remark and then Trish and Richard, as well, one of the things that is actually emphasized in the Affordable Care Act, it's a specific

policy initiative, and I'm wondering how much we ought to focus on this in our coming work, is sort of a variation on what Patty was describing, and that is not necessarily just a straight-up expansion of safety net programs, but the use of safety net providers, particularly community health centers, to provide practice support to physicians in primary care, which is growing in a lot of parts of the country through affiliation agreements where the physician remains in an independent practice but receives practice support services to deal with everything from social service needs to those patients who don't speak English to additional services that the practice itself doesn't offer and things like managing referrals.

I don't know -- I'm sure you probably would not have picked this up in your interviews, that is how many people who are health-centered physicians or who are -- you know, actually may e some hybrid. This is sort of a new world, and I'm thinking that maybe it's an area that might be somewhat fruitful for us as opposed to just coming back to the same old thing of raising fees and seeing that the fees really don't matter, but what really may matter is a structured practice support system either through public health or through a safety net provider.

DR. SOMMERS: Yes, that's an excellent point, and certainly there are physicians that split their time in different practice settings.

And your point about the supports being handled by certain institutions makes a lot of sense. I mean, already, solo and small group practices, you know, come together through associations and through county-based programs to purchase billing services and after hours on-call services, those kinds of things, and so to tack on also the nurse help line and non-physician support to find specialty referrals would certainly be a vehicle do that.

COMMISSIONER ROSENBAUM: I am assuming that actually the way the ACO policy will play

itself out ultimately in Medicaid is that we will see confederations of practice networks that are medical homes and medical home supported models with common EHRs, common incentive arrangements, and essentially a system for making sure that no physician is practicing in a small group that can't provide the critical basic supports, and I think that thinking about whether current policy supports this movement forward in the organization of primary health care, putting aside direct investments in safety nets themselves, might not be good for us.

DR. SOMMERS: I should point out that there is a trend that has been noted in other studies, particularly the CTS site visits, that hospitals are buying up group practices as fast as they can, and in some markets there is fierce competition between hospitals to get group practices. Interestingly, every single group practice that we interviewed was either in the process of selling their practice, had just been bought, or were putting it on the market and hoping for a sale. So I think there are some trends that could end up benefitting Medicaid patients through greater affiliation with hospitals.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: I was just wondering, in my own practice, I have a no-show rate of about 33 percent total and about 50 percent on my GYN patients, so I was just curious if that played into any of the people's comments on why they didn't want to take Medicaid patients or whether that's just true of anybody anywhere.

And then the other issue is did anybody, or did you hear about malpractice in any of this? Was there any conversation on that issue?

DR. SOMMERS: You know, malpractice, I don't think, came up at all. The no-show rate was mentioned. It wasn't commonly mentioned. And it is known -- I don't think I can cite a study, though --

that no-show rates can be high for Medicaid populations, more so than other patients. But there are managed care plans that are trying to do something about that. I mean, Burt knows about what is going on in the dental vendors who are really trying to work with dentists, because that is one of the singular complaints that dentists have about Medicaid patients is they don't show up. So there are studies being done by the private sector to figure out what the problem is and buying vans to go pick these people up and get them to the doctor. Really hands-on intervention can be needed for some of these hard-to-reach populations.

COMMISSIONER MOORE: Thank you very much. This is very helpful. One of the things the Commission has focused a lot on in recent months has been high-cost, high-needs populations and I didn't see too much -- and, of course, that also has a great impact related to specialty questions. There are a lot of people with disabilities, a variety of sorts of disabilities needs specialty care fairly often. Did the kind of patients come up in your work and do you have any insights for us on services to people with disabilities in particular and the workforce for that?

DR. SOMMERS: Yes. We did probe, you know, if they served Medicaid patients, what is the profile of your Medicaid patients. What kinds of people do you have come in, ages, chronic conditions, disabilities. We only found one physician who specifically served people with disabilities and he did it highly selectively through an association, a charitable association. He took referrals from them, and that is it, so a couple of patients a month.

So, I mean, that was the qualitative portion of our study. We could not get it added in the survey data. I suspect it is a huge problem. I mean, it is already a problem for relatively uncomplicated situations, like orthopedics, to get a referral. So when people have that additional chronic burden, trying to

break through into the specialty referral networks can be pretty complicated.

COMMISSIONER CHECKETT: First, I just want to compliment you on the study, because it was really interesting. I was struck by the logic of it. We have, I think, as people involved in Medicaid, have struggled for years about what is the right solution and what do we need to do, and lo and behold, it is almost like, look at it. The people who are serving the population right now are relatively happy serving the population and the ones who don't want to have anything to do with it, probably actually no matter what we do, are not going to take the population. And it is so obvious that we should all have kind of a moment of slight embarrassment.

[Laughter.]

COMMISSIONER CHECKETT: But moving on from that, actually, I was excited by it because I think it really gives us as a Commission some real grounds to dig in, ask some more questions, and I think this could really lay up some great work for us to do in the future about recommendations that are finally supported by some common sense research and data about how can we increase our providers seeing this population. So, really, my compliments to you for something that was well written and made sense. Thank you.

DR. SOMMERS: Thank you. Am I -- do you have time for me to respond to just one thing? I just want to point out that I take a somewhat different viewpoint about the analysis in that I think there are a lot of doctors who are on the fence about serving more Medicaid patients. They already take some, but they limit their panels for many different kinds of reasons. You know, they only work with one managed care plan in the area that pays the higher rates, or the group practice CEO said we can't take any more than 20 percent of our patient panel because we all have to pay an equal share of our overhead. There are

different decision makers and different decisions.

A third of the PCP supply takes, you know, a relatively substantial portion of their practice in Medicaid, so if we were able to convince them to take just a few more patients, you know, across a third of the supply, that could actually be a significant volume. So just turning, just convincing some of those people to take a few more, I think, could have an impact and somebody should do a quantitative analysis to figure out.

CHAIR ROWLAND: So sort of dialing up as opposed to just trying to wholesale cover.

DR. SOMMERS: Yes.

CHAIR ROWLAND: And I know that Jennifer has some slides to share with us on the quality aspects of this part of our discussion, and then we want to get back and talk about the overall chapter.

MS. TRACEY: Okay. Thanks, Diane.

CHAIR ROWLAND: And they are also in your book, but they're behind the outline, I think.

MS. TRACEY: Okay. Great. I just wanted to wrap up our session today by giving a brief update on the Commission's Quality Agenda -- proposed Quality Agenda for 2011-2012.

Based on the discussion at the last Commission meeting in September, we learned from all of you that examining quality and further examining the landscape of Medicaid quality is an extremely high priority area for the Commission in the coming reporting cycle. Quality measurement monitoring improvement have received increased attention in Medicaid over the last several years, and particularly at the Federal and State levels where there has been quite a bit of interest around what the quality landscape currently looks like in Medicaid and particularly how best to measure care for individuals with Medicaid and looking at what innovative approaches States are undertaking to drive quality improvement.

At the Federal level, there are certain requirements that States must meet for monitoring quality of care, for example, external quality reviews for Medicaid managed care organizations, in addition to addressing other key quality provisions, such as Medicaid provider participation requirements for hospitals and long-term care facilities.

To date, little is known as to what extent States are currently linking payment to quality and the outcomes of those efforts, and this is due in part to a lot of these programs are in their infancy and the data is not yet available.

Specific quality tasks that we're looking to undertake based on the guidance we received from you for 2011-12 include assessing some of the more commonly used quality measures that are applicable to Medicaid enrollees and placing a specific emphasis on measures that can be applied to persons with disabilities and also those persons who are dually eligible for Medicaid and Medicare. And this will become even increasingly more pertinent as states have expressed interest, as we've heard, into moving these populations into Medicaid managed care. And so it will be very important to understand which quality measures are appropriate for these individuals in monitoring quality.

As you may recall, at our last meeting one of our quality panelists did mention that there are currently not many measures available for monitoring the quality of care for these populations, so it's an important area that we're going to look into further.

Another project that we're going to be undertaking is trying to understand how states are attempting to monitor quality and specifically link payment to quality improvement. And so we'll be undertaking case studies for several states to look at some of the more innovative approaches, and we'll be sharing those with you.

And, finally, we'll be summarizing some of the key existing federal quality provisions and then also examining the proliferation of the vast array of quality tools and measures that are available to states and providers.

At this point I think we would love to get your feedback and guidance on our draft outline and any other guidance you'd like to provide us with for our quality agenda as we move forward.

COMMISSIONER MOORE: It is wonderful to note that the measurement of quality has come a long way in the Medicaid program in the recent past, but there are a lot of things on the list, and we will need to prioritize them, I think.

For my own self, I think, again, as I mentioned a minute ago, our emphasis on high-need, high-cost populations should be factored carefully into this agenda and should be part of our priority setting. I think we need to know more about measures that are already being used in a lot of places but have never been brought together, there is not as much transparency among states and plans as to what they are using and how they are using those, especially with managed care. I think there is a lot of quality management that's required by states in their contracts, but we don't necessarily at a national level know what that is all about.

We need to look at quality measures across fee-for-service in managed care because if you've got one, you've got one, and you really need both.

And then when you get to the things that we were just talking about around access, and particularly specialty access, I think that becomes a massive quality question as well. If you don't have access, you certainly don't have quality, and, again, particularly for the high-need, high-cost populations.

So I guess that would be, in terms of my own feelings, a statement of priorities for the kinds of things that I would like to see the Commission be doing in the next few months.

VICE CHAIR SUNDWALL: Yes, I would just like to encourage you -- I think Patty mentioned it earlier -- that we not just do a compendium of quality measures and see what's out there, but that we link it was value. What ones are actually helping us determine what's worth paying for? I don't think -- no one is against quality measures or improved quality, but it's really only useful if, in fact, we're linking it somehow with return on our investment and we're making people healthier, not just checklists of things.

COMMISSIONER COHEN: Also, we had spoken a little bit earlier about the importance of trying to consolidate or align quality measures so that we're not just, you know, recommending proliferation of them. But I also think relevant to that issue is sort of looking at, like, for example, when you're talking about measures applicable to dual eligibles that I mentioned before, you know, that's sort of more like a bureaucratic term, not a kind of patient. But it is relevant in one sense because if you are looking at quality measures for a person whose quality is being measured across two programs, it's even more important that those align. So I think thinking carefully about where alignment is, not just the value, but critically important where people are sort of being -- their care is being paid for by multiple programs or something like that, it's even more important to think carefully about how those measures come together.

COMMISSIONER GABOW: One caution I would put out there on quality measures is while patient satisfaction is a component that we should look at, I think in the Medicaid population, particularly in managed care, that is the quality measure and does it really look at outcomes that, in fact, relate to value. That's a caution I would put out there.

The second caution I would put out there -- and maybe one of you has an answer to this, but it's been a question that I've asked and have never received a good answer to yet -- is that in these measures that look at patient satisfaction where the outcome is to say always something happens, I've really wondered in

the population that we're talking about whose lives have never been great, when was the last time that they thought a visit to the doctor or an admission to the hospital was the high point of their life. And sort of we don't have a good understanding when we're using -- or at least I don't have a good understanding, maybe someone does and could answer this -- a good understanding of how highly vulnerable, disadvantaged people actually rate experiences in general, that to the extent we're going to use patient satisfaction, when was the last time they rated something as superb always? My hypothesis is rarely given the terrible lives that many of them have had to live.

So those would just be two cautions.

CHAIR ROWLAND: You know, perhaps one of the things is you have to manage against expectations, too. They may have lower expectations. In some of the studies, I think, some lower-income patients have rated their care higher than more-used-to-being-served higher-income people have rated their care. So when you're looking at, say, waiting times, they're not as surprised by a long waiting time as someone of a higher income. So I think those are all things worth teasing out as you do your quality work.

COMMISSIONER MOORE: Not to make this even more difficult than it already is, I'd also like to urge that we take a look at this issue and some other ones that we have on the agenda in a larger construct that has to do with greater innovation in the Medicaid program, structural innovation in the Medicaid program. There's a paper just out by the National Association of Medicaid Directors that, you know, you all know about, the Commission members know about, which calls for more use of best practices. Certainly it would be nice to have more standardization across states, not necessarily mandated but through dissemination of best practices, dissemination of options that states can modify for themselves.

And I think that our work in quality and access can just reflect a greater interest in this larger area of concern.

CHAIR ROWLAND: Are there other comments specific to the outline of the proposed chapter or the scope of the proposed chapter?

COMMISSIONER HENNING: There's a number of quality initiatives directly affecting maternity are, and I don't really see anything in the outline specific to maternity care. So I don't know whether we need to add it here or whether we address it when we drill down into the maternity care piece. But there's definitely quality initiatives out there that are specific to maternity care.

CHAIR ROWLAND: Okay. Other comments on the chapter?

COMMISSIONER RILEY: I guess I might think that we might -- it's a nice compendium of what's there, and it will show us what has to be done and gaps. But what it won't show us is what do we do about that. And so given the NAMD letter about rapid cycle improvements, I wonder if there's not some addition to this that would talk about how you use quality measures to make rapid cycle improvements and sort of the next -- why quality if you're not doing something about it?

COMMISSIONER ROSENBAUM: And to that end, I think one of the things that we want to pay particular attention to is whether the Center for Medicare and Medicaid Innovation has targeted as actively as it has Medicare the use of its authority and resources to promote the kind of rapid cycle improvements certainly in both populations who are dually eligible for Medicare and Medicaid, but I'm also concerned that CMMI has not been sufficiently involved in or active in populations that are, as they say, Medicaid-only populations, whether it is children and adults with disabilities or perinatal where this whole such of CMMI to identify initiatives, put money out there, make it possible for states to come in, a group of

states, do something together, do it quickly, and then diffuse the knowledge would really be helpful. And I think that we want to specifically address in our report CMMI's role, or lack thereof, in the Medicaid program.

COMMISSIONER MOORE: I don't know whether that fits here or not, but I certainly second that loud and clear, and I know most of my colleagues do here at the table.

VICE CHAIR SUNDWALL: Just one more comment. In looking at the last section on the ACA, I understand -- if I understand correctly -- that's what's in the law now, all of these things. It's mind-boggling. Look what has been required now in the ACA that's relevant to all of these things. It's a huge long list. And I just wonder if it is not for us just to be aware of what's there, but if it's the role of MACPAC to take an assessment of those as to what we think is, in fact, necessary or should happen, or maybe not. We all know that the future of the act is under review, and that's not for us to worry about legally. But I have to -- I am kind of a bit surprised at the long list and the complexity. I wonder if we agree that all of that is going to move things forward.

CHAIR ROWLAND: Certainly that can be assessed. Many of the things here are, of course, demonstration projects under the ACA, and they may be helping us to learn best practices as well. So perhaps as Jennifer moves forward and the staff moves forward to this analysis, we could tease out what are measures that are required versus areas that are putting out demonstrations to try and look at developing some best practices and weigh that.

COMMISSIONER CHAMBERS: I'll be real quick. I might be missing it in the outline, but I don't see any real mention of looking at what Medicare is doing, because being a special needs plan, I mean, it is -- what CMS has done in driving quality and measurement for a plan that's both Medicaid and a SNP

plan, is it has turned our whole focus around as a health plan in following what Medicare -- I mean, for simplicity, but just the rationality of what they've done is really missing in Medicaid across the country. So just something to think about, to be looking at.

CHAIR ROWLAND: Great. Well. Thank you very much. Thank you to the staff and to Anna for joining us and for this discussion. I think we've got a lot of food for thought and a lot of future research questions to be answered.

Now we'll turn to our next panel.

And I think that's Chris Peterson to talk about children and pregnant women in Medicaid and CHIP and to help us to begin to define our agenda around looking at the future of -- maybe looking at some maternity care issues, looking at some other issues, and Chris Park I see will be joining Chris Peterson at the table. Chris and Chris, and both CPs.

MR. PETERSON: Yes, it's the source of much confusion. You wouldn't believe the kinds of e-mails he gets, that I get.

[Laughter.]

CHILDREN AND PREGNANT WOMEN IN MEDICAID AND CHIP

MR. PETERSON: No, I'm just kidding.

* Thank you very much. Based on your suggestions from the July retreat, we have put together an outline for a potential chapter in March that would cover these large-issue areas, and these issue areas are the broad buckets that were used Chapter 2 of the March report, so that was the general overview chapter of Medicaid. And, of course, the purpose here would be to drill down further into the issues of pregnant women and children in particular, and we really want your feedback on this, whether it's a separate chapter

for March or whether something should go in June instead, whether it should just be maternity and pregnancy versus children. So we just want to get your feedback, but as a starting point for the discussion, we're beginning here with this potential outline. So what I will do is walk through the context for the chapter: eligibility, benefits and cost sharing, and federal financing. And in addition to the usual federal financing issues, I also want to highlight the MACBasic that was put out since our last public meeting having to do with federal CHIP financing. And although you had reviewed that and are familiar with that product, this is the first time that it has been discussed publicly, even though it has been available on our website. And then I'm going to discuss service delivery and payment mechanisms, that is to say, managed care, fee-for-service, and primary care case management. And then, finally, it will be Chris Park who gets to talk about the really interesting stuff having to do with spending and utilization, some of the data issues, and some very interesting initial findings.

So in terms of the context, the point is that Medicaid and CHIP coverage for children and pregnant women is very important. Medicaid and CHIP cover almost a third of kids, and that's compared to about 8 percent of adults, so its reach is much larger, touching more than 40 million children in a given year. And we've also done some preliminary analysis that you have seen that is consistent with prior research that finds that Medicaid and CHIP children have access to health care that is better than the uninsured and that is often comparable to children with employer-based coverage across most measures. And then our latest finding -- and Chris will talk about them more momentarily -- is that 44 percent of U.S. births are funded by Medicaid.

So the eligibility, again, now focusing just on pregnant women and children, that mandatory eligibility is up to 133 percent of poverty, higher in other states, and currently, of course, there is a

maintenance of effort so that whatever levels states are at that is above 133 percent of poverty, they have to stick with those levels until at least through December 31, 2013. So it will be interesting to see whether states roll back at that point for pregnant women versus parents and other adult populations.

Eligibility for pregnant women includes at least 60 days postpartum, and certain non-citizens may be eligible for coverage. For children, mandatory coverage is 133 percent of poverty for zero to five-year-olds and 100 percent of poverty for six- to 18-year-olds. And then beginning January 1, 2014, the six- to 18-year-olds are also eligible up to that kind of new national standard of 133 percent of poverty. And as we had published in the March MACStats, CHIP's upper-income standard ranges from 160 percent of poverty to 400 percent of poverty across states.

With respect to benefits and cost sharing, for pregnant women regular Medicaid benefits can apply. In some cases states may limit benefits only to pregnancy-related services and those that address complications, but they can offer coverage, the full benefit coverage. And, in fact, in the new proposed regulation that does touch on pregnant women issues, the regulation proposes to make this full benefits coverage essentially the default, and if states want to do what is otherwise permitted under the statute and limit it somewhat, then they can do that.

Effective 2010, there is a new mandatory benefit for pregnant women: counseling and pharmacotherapy for tobacco cessation. This is an interesting one. With respect to the Congressional Budget Office, CBO, when folks typically approach CBO and say, "Hey, we'd like to spend money on this issue, and we think it's going to save money," CBO generally responds and says, "No, if you're going to spend money, you're going to spend money." But this was a case where the research was so clear with respect to the benefits of if you can get pregnant women not to smoke, the savings from fewer pre-term

births are enough that CBO actually estimated a slight savings because of this additional mandatory benefit.

Children, of course, are entitled to early and periodic screening, diagnostic, and treatment services, EPSDT. That is not a requirement under separate CHIP programs. There are several benefit options there. And children and pregnant women are generally exempt from cost sharing in Medicaid.

VICE CHAIR SUNDWALL: Chris, before you go on, we had previous discussions where I was kind of surprised, and just fill me in. What's the status of the EPSDT program? Is that scheduled to be terminated, or is there no longer going to be one in the future? There was some discussion about that.

MR. PETERSON: I have not heard such a discussion. As far as I know, it is in the statute, and I have not heard any claim --

VICE CHAIR SUNDWALL: Well, I misunderstood. It's secure or --

COMMISSIONER ROSENBAUM: And it is part of the benchmark as well, so it stays not only for the traditional children but for any newly eligible child.

VICE CHAIR SUNDWALL: Okay. Well, I misunderstood.

CHAIR ROWLAND: The comment earlier, David, I think was when we were discussing children with disabilities who transitioned from being a child onto the full Medicaid program as an adult and then lost their EPSDT benefit as a result of the age cliff that they went over.

MR. PETERSON: And it's also worth mentioning with respect to federal financing that under Medicaid, if a state covers certain optional adult preventive services with no cost sharing, the state gets a one-percentage-point increase for those services and, for those pregnant women, tobacco cessation services. So that is a bit of a carrot for states in that regard.

One key distinction of federal financing is that it is open-ended for Medicaid but not under CHIP,

and that leads me to a bit of a discussion highlighting the MACBasic that we put out. Some of the key points were that annual CHIP allotments are states' primary CHIP funding source, that it is based on a formula using states' previous CHIP spending, and that is either the prior year spending or two years before, depending; that those funds are indeed capped, so it is possible for states to exhaust their federal CHIP funding, although the current structure suggests that shortfalls that states actually experience would be relatively small and rare. But one of the big points -- and this was what I thought maybe you were referring to, David -- is that there is no funding for new allotments after 2015 for CHIP. So that's another kind of something that potentially ends as an issue.

One of the ways that shortfalls are prevented is that if a state is slated to experience a shortfall, there is a CHIP contingency fund. We had raised in Chapter 3 of the March report the possibility that a state theoretically could receive a contingency fund payment that was in excess of their actual shortfall. That did happen in 2011, as was mentioned in the MACBasic for a state that had an approximately $4 million shortfall and got a $29 million contingency fund payment.

CHAIR ROWLAND: Could you review that case just one more time for the Commission and how that happened?

MR. PETERSON: Right. So CHIP funding is limited, it is capped so that it is possible for a state to exhaust their federal CHIP funds. If that were to happen, then there is a formula that provides these contingency fund payments, and the contingency funds are based on your child enrollment in CHIP above a certain level. So it's basically saying we only want to pay for basically growth in your program, enrollment growth. That's what we're going to pay for first.

What happened in the case of this state was a fluke in terms of what happened was the state did an

expansion in CHIP from 200 percent to 300 percent, and it was an unintended consequence, I suspect, in the formula that their shortfall was relatively small. It was just enough to push them over that, but then the way the formula works is it says, well, how much did your child enrollment growth -- how much did that grow, and that ended up producing this kind of effect.

CHAIR ROWLAND: So that might, in fact, be an area that we as a Commission might look at, whether that is a place that should be readjusted.

MR. PETERSON: Right, because --

CHAIR ROWLAND: That formula interacts with the shortfall.

MR. PETERSON: Right, and it could be something as simple as, you know, a state should not receive a contingency fund payment in excess of whatever their actual shortfall is. It is also worth noting that the contingency fund balance is $2.1 billion. The bonus fund is available for certain child enrollment growth in Medicaid, and in 2011 $200 million were provided to 15 states, and the balance in that fund is $7.5 billion. But this last bullet is a very important point because I think what often happens is folks who dabble into CHIP a little bit look and they see these balances and they say, "Oh, here's money we can use for offsets." And I just want to note that that's not how it works when we're talking about simply unspent balances.

CBO recognized that the actual spending from these funds would be relatively low, so notwithstanding the budget authority, which is a separate issue, that unspent amount, because they said, "Well, you're only going to actually spend this little amount," that even if one said, "Oh, well, let's try to use this money somewhere," the only offset that you would get is that little amount that would actually be projected to be spent out of that. So it's a technical, complicated issue, but I just want to raise it so that

you're aware of, oh, we can use this money to expand CHIP or extend CHIP or something like that.

To the service delivery and payment mechanisms, as was discussed in our March and June reports, 60 percent of Medicaid children were enrolled in comprehensive risk-based managed care at some point during fiscal year 2008, and then if we look at separate CHIP programs, in 2010 81 percent were enrolled in comprehensive managed care, 14 percent in fee-for-service, and about 5 percent in PCCM.

Enrollment information on pregnant women is difficult to obtain, and Chris Park is going to talk about those issues. This is his first time to present before the Commission, and I personally am very glad he's here because he stepped into a gap to help us with our data analyses, and he has been a great addition to our team and has been able to produce very high quality analyses pretty quickly, and so he's got some findings he's going to present today here.

MR. PARK: Thank you, Chris.

Our primary source of spending, utilization, and enrollment data is Medicaid administrative data, such as MSIS. However, MSIS has a few limitations that I'll kind of walk through briefly in terms of pregnant women and children.

First, pregnant women in the MSIS data are not identified separately as a basis of eligibility. They kind of show up under a code of adult. So the only way to really identify pregnant women would be to do a claims-level analysis to look at maternity-related diagnosis and billing codes and use that to kind of determine their eligibility as a pregnant woman. Furthermore, since so many children and pregnant women are in managed care, managed care encounter data is reported kind of sporadically and is not necessarily complete for every state within MSIS. So that really limits our ability to do service utilization and spending analysis for the complete picture of pregnant women and children because most of them are

in managed care, and that data is not completely reliable at this point.

VICE CHAIR SUNDWALL: Chris, let me interrupt you there just because this catches me by surprise. If a pregnant woman paid for in Medicaid is in managed care, doesn't that show up at time of delivery as an episode of care that you could then see what their prenatal care and postnatal care would have cost? It seems like with our all-payer databases we can certainly capture deliveries, even in managed care, right?

MR. PARK: To a certain extent we can, depending on how well the managed care organizations in that state have reported their data completely and accurately. So, you know, some states might not do a complete submission of all of their encounter data, and there might be holes, because it's not really tied to the actual payment. The payment is the capitation payment that the state paid. So, you know, to a certain extent MCOs in states don't really audit the quality of that data, and if it's not reported, then we can't really tell that that person had an actual delivery. And so that's one of the issues and limitations of using the MSIS data. If we had the raw states' and MCOs' claims data completely, we could do that type of analysis.

One of the other options is to use hospital administrative data, so the Agency for Health Care Research and Quality, AHRQ, has put together this kind of national sample called the Health Care Cost and Utilization Project which looks at hospital administrative data. So this is particularly good to get a sense of utilization, and it also includes Medicaid managed care so we don't necessarily face that limitation that we do with the MSIS data. It allows comparisons across payers because they are collecting kind of like an all-payer database where they're looking at Medicaid, Medicare, private insurance, uninsured.

One of the unfortunate downfalls of hospital administrative data is they report hospital costs and charges, but this does not actually relate to the actual payment made by Medicare and Medicaid. So we get

a sense of maybe like the intensity, length of stay, you know, things like that, but we can't actually tie it to the actual payment that the hospital ultimately received by that payer.

The following slides kind of walk through some of the findings, our initial findings, using the Health Care Utilization Project data. As was mentioned before, about 44 percent of deliveries were funded by Medicaid in 2009. This compares to about 49 percent under private insurance, so these two payers pretty much fund almost all deliveries.

About 32 percent of Medicaid delivers were C-sections compared to about 36 percent for private insurance.

COMMISSIONER GABOW: I was surprised to see Medicare deliveries -- that must be a unique population. Do you have any information about that?

CHAIR ROWLAND: They're the women with disabilities, the under-65 disabled primarily.

MR. PARK: Right, and this is by who the hospital thinks will be the primary payer, because it is a hospital service, then Medicaid would be the primary payer on that.

On the flip side, we also looked at newborn discharges using the DRG codes, and Medicaid has a slightly higher rate of newborn complications when looking at premature births and births with complications. So about 32 percent of Medicaid newborns were either premature and/or had complications compared to about 31 percent for private insurance. So Medicaid does have slightly higher acuity on their newborns.

It's hard to say because I don't necessarily have all the sample size and everything, but, you know -- and there might be various other factors going into that as to what is driving the difference. So, you know, we haven't had an opportunity to really look at all of the data and to determine whether that is a statistically

significant difference or not.

Another thing we're able to do with the HCUP data is look at kind of different types of hospitals because children's hospitals do provide a great deal of care to children for Medicaid in particular. So, you know, we kind of segmented the hospitals into non-children's hospitals and hospitals, looking at hospitalizations for children ages 0 to 17. That's how they're identified in the database.

Children's hospitals do serve a different mix of patients and have a wider variety of cases. Children's hospitals have a higher length of stay, about six days, versus non-children's hospitals, which is a little over three days. And children's hospitals have higher average charges per discharge, you know, about three times higher, $35,000 versus $10,000 for non-children's hospitals.

One of the interesting factors is it seems like some of this difference is driven primarily by newborns. Non-children's hospitals primarily deal with newborns, and that's kind of what they do, where children's hospitals only have about -- like one-third of their discharges were newborns. And even within kind of the newborn categories, when you look at it, children's hospitals have a much higher rate of complications and premature births, so that's about 50 percent of the newborns in children's hospitals had complications of prematurity versus about 30 percent in non-children's hospitals.

COMMISSIONER ROSENBAUM: One question, which is, of course -- Herman, correct me if I'm wrong, but there are sort of two types of children's hospitals. There's a children's hospital that's a component of a larger hospital, and then there are independent children's hospitals. And I wonder where the children's hospital is really a division of a bigger institution, whether they might not, in fact, have more newborn care because they're physically there. Here in Washington, for example, you've got to move the child to Children's National, which obviously is done only for the highest-risk cases. Where the children's

hospital is actually a component of a bigger hospital system, do we know whether the --

MR. PARK: That information wasn't available. They just had kind of a flag that said children's hospitals or non-children's hospitals.

COMMISSIONER GRAY: You're absolutely right. There are lots of children's hospitals within hospitals. There's a larger number of those than there are the true free-standing children's hospitals, of which there are 55 or 60 maybe at tops. There's probably 150 to 200 hospitals within hospitals. There's a small number of true free-standing children's hospitals that do have delivery services, mainly high-risk delivery, so that the mom and baby are in the same place. But it's a pretty small number. But in the last ten years or so, there's been several places that have started that as new services. So there are some normal newborns in children's hospitals, but I suspect the number is even smaller than this.

MR. PARK: Right, and kind of the last bullet is non-children's hospitals, over half of their discharges are for normal newborns, where it's only about 20 percent in the hospitals that were identified as children's hospitals. And so you can definitely see kind of the different level of cases that they might be facing.

I'll turn it back over to Chris Peterson.

MR. PETERSON: So you have a draft outline for a potential chapter, and really the questions for you, we want your feedback on whether there are topics that we didn't mention that we need to explore if we were to do this kind of chapter. And of the topics that we did talk about, are there some that require a greater or lesser focus? And then are there additional analyses or data that we should be looking at as well?

CHAIR ROWLAND: Sharon, do you want to kick off our discussion?

COMMISSIONER CARTE: Yes. Well, Chris, I guess I need to start off by saying I was one of

those who, until your brief was completed, incorrectly assumed that there might be some leeway for transitioning through the use of the contingency or bonus funds, realizing early on that I could see when the CHIPRA passed that it was unlikely that those funds would all be used. But basically, also in addition to what you said about those costs not being able to be realized, the savings, since there's no significant outlay to be expected, also the Secretary of DHHS has no authority to reallocate anything under budgetary authority. So the states are kind of stuck.

I would just make the observation that in October we had the CHIP directors annual meeting, and Chris was there as well, and, you know, as we approach health care reform with a certain portion of the CHIP population being folded into Medicaid and then the rest headed to the exchanges, it was real apparent from the CHIP directors meeting that the states are all in very different places as they work on exchanges. Some are actively working towards an exchange. Some are strictly forbidden, not working on an exchange. And then there's the agnostic group where they're either quietly or in whispers working on an exchange.

So it looks like states will be in very different places, and it's a real concern as we approach that time that states could find themselves facing such significant uncertainties with respect to federal funding.

COMMISSIONER GRAY: One of the areas I think we need to understand better is the whole area of children's special health care needs. There's precious little data on how well these kids are served, what their access is like, both in fee-for-service programs as well as in managed care. There's that population of kids that are in the disability category that we can get a pretty good handle on, but there's a significant number of kids. Children's hospitals serve kids with asthma, kids with diabetes, kids with sickle cell disease, kids with all kinds of chronic illnesses that we really don't know much about, I think.

I don't know what our capabilities are of acquiring that data. Can you speak to that at all, Chris?

MR. PETERSON: Well, we took an initial cut at that. I think it was in the June report. In the MACStats one of the tables had to do with children, and part of that tried to break out children with special health care needs from those with disabilities per se, you know, those who were eligible on the basis of a disability. So we have begun to do that work, and I think your point of, you know, are there ways to dig down into that a little bit more, I think that is something we can try to do.

COMMISSIONER HOYT: Mercer spent quite a bit of time trying to analyze the risk of newborns, and I don't think there's any one perfect way to look at it, but the premature designation seemed a little loose and kind of hard to quantify or imprecise in the measurement. We pushed states to collect birth weight and looked at that as well, and sometimes you don't have consistent definitions of what a low birth weight baby is, but if we could get that information as well, or maybe we'd want to make a recommendation that they agree at 1,200 grams or 1,500 grams or some number, and then collect that data ultimately on a CMS 60 Form. I'm not clear on what the labeling is for that.

One other thing in the outline that I looked at that I think speaks to something we were talking about this morning on the C-section rate,, and I don't know how effective this has proven to be, but I do know there's a number of states that changed the managed care reimbursement for maternity care sometime ago out of concern for the C-section rate growing. It's usually called -- that's called a supplemental payment or a kick payment. It's kind of like a maternity case rate. It would be several thousands of dollars and a plan would just get paid the lump sum for each delivery, whether it was vaginal, C-section, typical for multiple births or a single birth. I believe in at least several states where they use that, it was somewhat effective in holding the C-section rate down. It might also be an indicator of how many births there were, too, if we had a better reporting mechanism on the supplemental payments. So something to

think about there.

CHAIR ROWLAND: Patty, you're next.

COMMISSIONER GABOW: A couple of questions or comments. Do you know, out of the Medicaid payment for delivery, how many are emergency Medicaid and what the trend is in that? I think that it may be something you would like to know. I also, while this definition may be hard to come by, do we know about patients who are at high risk OBVIOUSLY in these funding categories, which again I think would be interesting.

And then to get to the C-section, I think it would be useful to have the trend of the C-sections by payer over time of the payment rates. An area that I know we've been interested in and have been talking to CMS and the March of Dimes has been deliveries before 39 weeks because it's not so much that the C-section before 39 weeks. Has a higher C-section cost of those babies have higher NICU costs?

So I think if we're going to dig in to payment around maternity care, I think looking at that 39-week break point is important to look at. And to the other, Chris, this table about percent premature with complications, you make the comment that 32.4 compared to 30.7 for private insurance, but the more startling number is 32.4 for premature with complications in Medicaid and 29.3 of your uninsured, which could drive you to some very unusual conclusions.

But is it possible, someone who knows more about this than I do could answer it. Is it possible that the premature babies with complications whose mothers are uninsured actually go onto Medicaid. Is that why this looks like not having any coverage is better for you?

MR. PARK: Yeah, so first of all, these numbers are done by primary payers, so I think what you're asking about whether the mother was uninsured but the baby got picked up by Medicaid is possible because

if it is a premature birth, it's a very high cost birth and they might fall under kind of like the spend-down type of situation where they kind of know because they are premature that they're automatically going to get qualified through various other eligibility pathways. I don't know if you have anything else to say, Chris?

MR. PETERSON: Just as a point of clarification. So you're right that there are women who will come in uninsured and they ultimately get Medicaid. And the way that these data are structured is that it recognizes that. So this is not payer based on admission.

COMMISSIONER GABOW: I see.

MR. PETERSON: This is kind of after the fact, once we've gotten --

COMMISSIONER GABOW: So this is very unusual.

MR. PETERSON: Yeah.

COMMISSIONER ROSENBLUM: I assume it's demographic. I assume that the answer is that the uninsured population is much more likely to be a Hispanic population where the incidents of prematurity for reasons that people don't understand completely actually, that really don't understand it, is a lower incidence than you have, for example, among an African-American population where prematurity is higher. So what we're seeing is the effect of a lot of undocumented births where nobody was able to get the person out.

I mean, to me, actually it's a real indictment of the poor working of the Medicaid emergency coverage system. That is to say, that by keeping undocumented women and their newborns out of the program, there's a big gap between the existence of the benefit and who gets on.

And so, that number, the number, I think, maybe it is as much. I was shocked actually that the number of uninsured births is as high still as it is.

COMMISSIONER GABOW: Could I ask a question?

CHAIR ROWLAND: But I think there's one important thing when we try and interpret what's going on and that's to know more about who the people are. There's also a chance that these uninsured patients are actually higher income because they didn't qualify for Medicaid to provide coverage for them, and the hospital certainly has a strong incentive to get anyone who qualifies onto Medicaid. So these may well be higher income people or they may be immigrants that aren't emergency that are in the five-year plan.

MR. PETERSON: And yet another example of the selection bias that we really could be seeing here, that is to say we're looking at differences in the underlying populations rather than -- that are different than what we would expect, a priori, is private health insurance.

There may be older women who are more likely to have the C-section and who are likely to have therefore some complications with the newborns. So unfortunately, all that gets rolled up into an average that says, Wow, these really aren't much different and maybe or maybe not this lines up with what I thought. So there's a lot going on here.

COMMISSIONER HENNING: When you say prematurity/ complications, are you saying these are preterm births that have complications or are you saying they're either preterm or they have complications?

MR. PARK: It's the or. So basically all the non-normal newborns, so rolling up the DRG's that were not normal newborn DRG's.

COMMISSIONER HENNING: Okay. So I think we really need to tease that out.

MR. PARK: Right. And I've looked at it at the individual DRG levels and it was still kind of a similar difference between Medicaid and private insurance for each specific DRG, so roughly like 2 percent

higher for Medicaid kind of consistently, you know, 1 to 2 percent higher. So there wasn't necessarily -- like the extreme prematurity births were not necessarily that much higher for Medicaid than private insurance.

CHAIR ROWLAND: I'll go to Burt and then to Donna because Burt's about to turn into -- he's got his mic on.

COMMISSIONER EDELSTEIN: Well, I have a much easier question that doesn't require conjecture. I just have a basic arithmetic question. In a couple places in our materials today, we list that a third of the children are covered in Medicaid or CHIP. Nearly 40 million children are covered.

There are, according to census, 77 million kids under the age of 19. So 40 million is more than half. What am I doing wrong?

CHAIR ROWLAND: It depends on whether you do 18 or 19, is one question.

MR. PETERSON: Yeah, I don't know. I'd have to look at the --

COMMISSIONER EDELSTEIN: If we excluded 19.

MR. PETERSON: -- at the denominator. I mean, the numbers that we pulled were straight out of the MACStats that were --

COMMISSIONER EDELSTEIN: That's been a problem all along. And I think it's something that we ought to be really, really solid on.

MR. PETERSON: No, no, no. And that's why, I mean, Table 1 in the June MACStats made this point clearly, that you can get a higher or lower percentage of this depending on what your denominator is and how you're counting, you know, whether kids were ever enrolled during the year or the point in time. And so, I'd just have to take a look at the numbers.

COMMISSIONER EDELSTEIN: Okay. Well, let's take a look because as a premise for this chapter, we want to get that as straight as we can.

CHAIR ROWLAND: Donna.

COMMISSIONER EDELSTEIN: I've got one more.

CHAIR ROWLAND: Please.

COMMISSIONER EDELSTEIN: The other half was, when we're dealing with children in both Medicaid and CHIP, the dental issue is a surprisingly potent one. For example, when CHIP was being enacted initially in '96, '97, there were some actuarial studies done that surprised everyone when it was discovered that fully a quarter of child health expenditures go to dental care, something that nobody had anticipated.

So my request is that as we look through this outline, there are quite a number of places where we can identify the unusual attributes of oral health care for children and integrate them throughout the chapter.

MR. PETERSON: No, that's a great idea and the MSIS data, if I remember right, of course, I think they provide the ability to pull out dental services. So in a fee-for-service, to the extent that that's provided in a fee-for-service arrangement, then we can get at that.

COMMISSIONER EDELSTEIN: They are also typically contracted as carve-outs in managed care. So to the degree that we have data from managed care, the reports can be identified separately.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: I have an also equally simple question and an observation. I'm interested in the number 44 percent of deliveries because that's up than from where it was, you know, I

mean, I remember when it was 40, then it went down to 37. Now I turn around and all of a sudden it's 44.

And I'm really wondering, do we know why that is? Is that a function of the recession? Does it mean more states have increased their percentage for eligibility? They've gone up from 133 to 185? I don't know that we have an answer now, but I would really like to know that.

CHAIR ROWLAND: Or is it a different database, whatever?

COMMISSIONER CHECKETT: Yeah, but there's enough of a point. I don't know. I would just ask, I guess, ask us to dig in and I think a chart trending that would be fascinating and just then it would be conjecture as to why that's happened, unless somebody knows.

Because I always think when we look at Medicaid, that is the attention-grabbing statistic that gets more legislators, you know, either riled or excited, depending on where they sit. But I think it's an important number and I want to be really clear on it.

And then my observation on some of the discussion we've had on reimbursement and how you can have very unintended consequences is when I was in Missouri Medicaid, we really increased our OBVIOUSLY reimbursement. And we had this huge increase in providers which is something we wanted, and then we paid different rates for vaginal and C-sections, and didn't see much of a difference.

But then alas, we had also gone to a global payment, which the docs loved and we lost all our data on how many prenatal visits and NSG's and everything else that was happening. So kind of a combination of it worked, it was a great idea, and then a couple years later, we were really at a loss. So just a war story. Thank you.

CHAIR ROWLAND: Sara? Sharon?

COMMISSIONER CARTE: Yeah. I just wanted to quickly ask the Chris's, to look at the data

by payer. I don't know about prematurity, but don't we sometimes go back to the vital statistics data that is reported to HRSA? Is that not a better measure for whether a payer --

MR. PETERSON: I think that what I've heard is they collect payer information, but it's not publicized.

COMMISSIONER CARTE: Well, Title V surveys that.

MR. PETERSON: Yeah, I don't know, but we'll look into that because you're right. I mean, that information is available so we'll look into that.

CHAIR ROWLAND: But we should also have access to that even if it's not public. Sara, sorry.

COMMISSIONER ROSENBLUM: Just going back to our discussion about EPSDT, which obviously comes up as a big issue in Medicaid and pediatrics, I have found that there's a lot of confusion about the benefit. I mean, this has been around for, what, 45 years and there's still a lot of confusion.

I think it would be very helpful -- I can't remember what we had in our first report where we discussed, of course, EPSDT, but I think some simple charting showing people what the differences are in benefits and cost-sharing.

The other thing that I think is very instructive, which I have not seen a lot of, but it is very helpful is to look at per capita payments for children under Medicaid, under separately-administered CHIP programs. And what you see, which is a testimonial, I think, more than anything to provider payment rates, but I'm not sure, is that despite the great breadth of the benefit and the zero cost-sharing, per capita payments for children in Medicaid are very low.

I think it would be very good to remind people that if you look at children who we classify as AFDC-related, children who are poverty-related children, for the SSI children obviously it's going to be

much higher, that despite the breadth of the benefit and despite the total protection against cost-sharing, per capita payments are low.

I'm not sure what they are in separately-administered CHIP programs, but my guess would be that there's not a lot of difference, even though, in fact, the benefit design is quite different. I don't know the answer to that, though.

COMMISSIONER CARTE: That might be a question worth exploring or getting data on because in West Virginia we don't have a maternity benefit. We help coordinate the enrollment of CHIP teens who get pregnant into Medicaid or through payment by Title V, and that decision was made early on when the Board set up the benefits. And I can't tell you. Normally I have a sense of what all the separate CHIPs do, but I don't in this regard.

MR. PETERSON: And I think that data is get-able. When I was at CRS, we had the PMPM's on separate CHIP programs. So you could compare that. But I think you're right, because a lot of the separate CHIP programs tout that they are closer to private commercial rates. So that is going to be a confounding factor of that.

CHAIR ROWLAND: Chris, a number of years ago the Congress set up a Secretary's Advisory Committee on Infant Mortality that reported to -- it was staffed by HRSA, but it was to report back to the Congress. And I know they did a great deal of work on deliveries and on other factors. It may be worth finding out if they're still in operation, or at least referencing back to some of their reports to Congress.

VICE CHAIR SUNDWALL: Maybe I'm wrong, but I served on that commission on behalf of Secretary Bowen. It was the mid-'80's, if that's the one you're talking about, the National Commission to Prevent Infant Mortality.

CHAIR ROWLAND: Yes.

VICE CHAIR SUNDWALL: And it stated, but we did have -- it's time limited and we did have a report to Congress, but the time was very good and I think the issues are probably very much the same. But the data will certainly be different.

CHAIR ROWLAND: I served on it under Secretary Shalala, so it's been around for quite a while. Andy? I just know that it was responsible for reporting to the Energy and Commerce Committee and to the Finance Committee, and I don't know that it's still in existence, but it was looking at many of these issues.

COMMISSIONER COHEN: Chrises, not sure about the availability of this data, but I'm really interested in Donna's observations about sort of experimenting with different payment methods for deliveries. I'm just wondering if there's anything -- I mean, it's one service, it's extremely widely used, consistently over time, techniques are probably fairly consistent across the country.

I'm just wondering if we might not be able to do some -- look at some longitudinal sort of experience across different payment -- you know, look at a state that paid one way and then another way and look at any sort of differences in outcomes or anything else, or C-section, vaginal rate or anything like that, and do that across a number of states and just see if there are any lessons that we can draw.

I mean, each state presumably learned something from their own experience, but who collects that? Is anybody collecting that and trying to actually develop some lessons learned about what are some payment methods that make a difference in one way or another.

MR. PARKS: Sure.

COMMISSIONER COHEN: That may be wildly unrealistic to think that we could actually get

that, you know, on a steep level.

MR. PETERSON: Go ahead, Patty.

COMMISSIONER GABOW: While this number of 44 percent of deliveries is a startling number, do we know what percent of Medicaid costs that represents?

MR. PARKS: So this is kind of one of the limitations on some of the administrative data that we have, is that, you know, we don't -- it's hard to identify all like maternity and delivery-related services because so much of that does happen in managed care. We don't know necessarily how many of those are happening in managed care. So some of that data is limited by the quality of the reporting.

Like Mark was saying, there are states who, in managed care, they do a delivery Kick payment so if we looked at that as a proxy for, you know, because it is kind of actuarially sound developed payment, it should kind of encompass what the state thinks represents, you know, prenatal, postpartum, and the delivery. So that could be one proxy as to determining how much an average delivery costs in those states with managed care.

And in states that are completely fee-for-service, we could probably do some analysis of the average cost of delivery by looking at those particular like DRD's or diagnosis care procedure codes to kind of come up with kind of our own type of Kick payment, you know, by bundling all those together.

CHAIR ROWLAND: Judy, then Mark.

COMMISSIONER MOORE: This is kind of a classic Medicaid situation that we find ourselves in and we have for decades in that it's an incredibly important subject and we don't really know much about it, because the data is so poor. So I just want to put it on our radar screen that when we start talking about data again, this could be a real high priority for cleaning up and getting more specific information and

requiring maybe a better reporting by states and plans and everybody else who's got some skin in the game.

CHAIR ROWLAND: But this also may be an issue where national data is going to be hard to obtain at the level we want, but perhaps working with one or two states who could share with us some of their data would give us an insight into what's going on and we could more directly relate that to the payment policies, because then we could match what's happening to the payment policies. And I'm sure states at their level have better data on this than we probably do from the national data. Mark.

COMMISSIONER HOYT: I think I might be able to answer the 44 percent question. I'm not sure. I know I remember at least part of the riddle because it surprised me when I heard this. There's been a bunch of stories in the last year about the census data from April 2010, and there was a question asked centered around sort of women in the age of fertility, not teenagers, but like 20 to 44.

I believe they hit the lowest percentage ever since they started asking this question in the 1950's or something of women who are a mother, who have had a child. So two sort of mega trends. And I think these are tending to affect people not on Medicaid more than people who are on Medicaid, people choosing to wait until later age to get married, people waiting longer still to have kids, and people having fewer kids than they used to have.

And the 44 percent is the Medicaid burst divided by all the bursts. So if the Medicaid bursts are not slowing down as much as the general population, then that percentage is going to rise.

CHAIR ROWLAND: Okay. It's just math. Well, I think this is very helpful in terms of giving the two Chrises some more work to do. Also, clearly what we've talked about throughout this is that once we get into it, we really need to look much more specifically at the maternity benefit at the way in which the maternity care is being delivered, at the outcomes from that and how to measure it.

And I think that the outline here, which really focuses a lot more on children, I think, we're really focusing into one having maybe to go drill deeper on the pregnant women and on the way maternity care is delivered. And I think we have one particular Commission member who would really say rah, rah to that one.

Thank you, both, very much. Let's take a ten-minute break and we'll reconvene. Ten minutes always is 15, but anyway.

[Recess.]

CHAIR ROWLAND: If we could please reconvene, I want to welcome our panel and our topic and ask the Commission members to please take their respective seats. The panel is ready.

Okay. We are now going to turn to a topic that we know is a central issue in the states as well as at the federal level in discussing and looking at the Medicaid program and looking at the challenges within the program and how the states and the federal government share their obligations to both ensure the appropriateness of the payments and services provided under the program. So I am going to turn to Caroline Haarmann our senior analyst with the MACPAC staff, to introduce the panel and set up our discussion.

PROMOTING MEDICAID PROGRAM INTEGRITY

* MS. HAARMANN: Great. Thanks, Diane.

In today's session on promoting Medicaid program integrity, the Commission will hear from representatives from CMS' Center for Program Integrity, Virginia's Department of Health and Human Resources, and Ohio's Medicaid Fraud Control Unit to learn about efforts and initiatives at the federal and state levels to improve Medicaid program integrity, coordination of these efforts among federal and state

agencies, and challenges faced when trying to manage program integrity activities.

MACPAC's June 2011 report to the Congress included an overview of federal and state program integrity efforts, and since then the Commission has begun work to provide additional information on this topic, including an upcoming MACBasics that provides an overview of current federal and state program integrity oversight efforts and functions. A draft of this Basic has been provided for your review, and we look forward to your feedback.

We have also provided you with a draft chapter outline for the March report that builds on the MACBasics as the Commission requested and proposes to examine oversight efforts, coordination, and data issues, and we look forward to getting your feedback on this as well.

As you know, the Medicaid program is a major payer of health care services in the U.S., accounting for 15 percent of total health care spending in 2009. In fiscal year 2010, Medicaid spending totaled $406 billion with the federal share accounting for about two-thirds, or $274 billion. In addition, states and the federal government share a statutory obligation to ensure that state Medicaid programs have procedures to safeguard against unnecessary utilization and that program payments are consistent with efficiency, economy, and quality of care.

Program integrity is important because meeting this obligation requires effective program management as well as ongoing program monitoring at the federal and state levels to detect and deter fraud, waste, and abuse as these efforts affect the ability of states and the federal government to ensure taxpayers dollars are spent appropriately.

Given the size and scope of the Medicaid program, there are a number of activities intended to prevent fraud and abuse from taking place. This includes efforts to ensure that eligibility decisions are

made correctly, prospective and enrolled providers meet state and federal participation requirements, services provided to beneficiaries are medically necessary and appropriate, and provider payments are made in the correct amount and for appropriate services.

There are also a number of initiatives to identify fraud and abuse once it has already taken place and enforcement actions against those who have committed fraud and abuse against the program. Likewise, there are a number of agencies that work to address program integrity issues at both the federal and state levels which can make communication difficult.

Moving forward, the Commission plans to examine program integrity oversight efforts, coordination, and data issues. Some pertinent questions for the Commission's consideration include: What initiatives and programs do CMS and states currently have in place to improve program integrity in Medicaid? What programs and efforts are most effective? What are the challenges in measuring program integrity efforts? How effective is communication among state agencies and between states and the federal government? And what challenges do CMS and states face in managing program integrity activities?

Now I would like to introduce our first speaker, Angela Brice-Smith from CMS.

CHAIR ROWLAND: Welcome, Angela. Thank you for joining us.

* MS. BRICE-SMITH: Thank you. I'm glad to be here with you.

First I want to just tee up a distinction about the Medicaid program as compared to the Medicare program just to make sure everyone is on the same page. The Medicaid program is administered by the states, and the federal government plays a role in the sharing of the costs of those services that are provided. We also, of course -- and I'm going to get into a lot of that information -- share in the role of program integrity. That role recently came into being through the Deficit Reduction Act of 2005 that was passed in

2006. So when you think about the federal program integrity role, it's a fairly young program in terms of its existence.

Next slide. Not very good color coordination there.

Let me talk a little bit about the Center for Program Integrity. Back in April of 2010, Secretary Sebelius decided that she wanted to have greater leverage and synergy across the Medicare, Medicaid, and CHIP programs, all federal health care programs. So she decided to develop the Center for Program Integrity within CMS. Our central purpose of CPI is to ensure correct payments are made to legitimate providers for covered, appropriate, and reasonable services for eligible beneficiaries of the Medicare and Medicaid programs. I have tried to emphasize a few key points: legitimate, medically necessary services, if you will, eligible beneficiaries across both programs.

Our vision is to use the highest state-of-the-art technology and methods to prevent and detect fraud and reduce waste and abuse and improper payments in the Medicare and Medicaid programs. You're probably aware of the recent announcement about the reduction in the Medicaid improper payment rate from $22.5 billion to $21.9 billion, so we still have a lot of work to do.

Our four key approaches to PI activities are prevention, detection, transparency and accountability, and recovery. Now, when you think about prevention, I think the mind-set, of course, with Dr. Budetti as the head of CPI, is that we should move away from pay-and-chase methods and try to move more toward prevention. That works very well in the Medicare world since CMS controls both of those.

In the Medicaid world, I am a little bit more challenged because the states have all of the claims. I get a subset of the claims after a number of months, sometimes years. So it's a little bit more difficult for me to be prevention oriented, but we're working toward more universal data quicker so that we can be more

proactive and certainly move more toward the predictive analytics that you're probably going to be hearing more about in the future.

Detection is another big piece of our effort in terms of using technology, the tools, the development of algorithms to basically mine and target where we think the vulnerabilities or the risks or the improper payments are.

Transportation and accountability is another aspect of our program. You'll probably see, if you haven't seen it yet, our website is very aggressive on the Medicaid side in terms of what we're doing. We recently published the first Medicaid Integrity Manual. We describe every activity we do with the states in terms of the state comprehensive PI reviews. So we try to put the information out there in terms of what our findings are, what we're concerned about, what we want to alert the states to.

Then the final approach is recovery. It means nothing without recovering the overpayments that are identified and making those dollars -- making us whole, making the states whole as well in terms of bringing those dollars back to their proper place.

One aspect of our program -- I sort of view it as two lines of business if you were to look at it in simplistic terms. One is post-pay activity in terms of audits, and the other is technical assistance and support to the states. So a big portion of that support to the states is through what we refer to as the Medicaid Integrity Institute, and this has been in existence since 2008. It's a partnership we have with the Department of Justice, their National Advocacy Center in South Carolina. And we have trained over 2,200 state employees at no cost to the states. So when you look at that curriculum, we cover the gamut from how to build a better referral case for your Medicaid Fraud Control Unit or your attorneys, to how to data mine, how to be more productive in the use of data to address fraud and abuse. So there's a lot of activity

in that institute with a number of courses. I think next year we're planning on having over 22 courses, and we also try to do course work that readies the state for new initiatives such as ICD-10 or new things that we want to make sure the PI officials know how to use that tool and use that information and incorporate that into their daily work.

The courses also provide an opportunity for the state staff to engage with each other in terms of challenges, in terms of best practices of how states do things differently, and how to leverage some of that expertise in a more efficient manner.

We're also exploring the credentialing process in terms of this has been requested by a number of the state participants about validating their professional qualifications and credentials as program integrity professionals.

Another aspect that is getting a lot of traction -- and you've probably become aware of it from the Medicare side -- is the National Fraud Prevention Program. That integrates two key aspects or activities that came out of the Affordable Care Act in terms of provider screening. Claims processing was there anyway, but it's an aggressive effort at risk of certain providers and capturing that and applying a higher screening risk to those providers and applying that.

The coordinator program will permit CMS to prevent bad actors from enrolling in Medicare and to share that information with state Medicaid programs. So what we're trying to do with that tool is since roughly we estimate about 70 to 80 percent of the providers in this country in the Medicaid side of the world also are dual participating providers on the Medicare side of the world. So that's an opportunity for the states to have some synergy with depending on the enrollment process of the Medicare program so that they don't have to repeat the same enrollment and risk assessments.

Prevent the payment of fraudulent claims and remove bad actors and suppliers from Medicare and Medicaid, and prevent payment of improper claims with quick administrative action. Let me say a little bit about the second point about preventing payment of fraudulent claims and removing bad actors and suppliers from Medicare and Medicaid.

Right now with any termination action -- and I want to make the distinction between termination and exclusion. That's different from what some may refer to as the OIG or the Office of Inspector General exclusion list. A termination action is a CMS action whereby there's a revocation of billing practices or billing. There's administrative action. So if we take a termination action on the Medicare side, that can be conveyed to the states in terms of if they're terminated by Medicare, then they have to be terminated by Medicaid and CHIP and vice versa. That's provision 6501 of the Affordable Care Act. So we've built a database to basically allow the states to share that information across the states so that they can be warned and they can communicate any of their termination actions across to other states so then they can also make sure that if they're terminated in New York, they shouldn't be practicing in Kansas. That mobility, that can be cut off through that tool.

We're also exploring -- and the whole point of part of that slide was to mention that CPI is exploring options to expand the fraud prevention system-like technology to Medicaid, so that's sort of in the works now in the early stages, but that's something we're working towards as well.

In terms of detection strategies, we do what we refer to as those post-pay audits, the traditional audit. Our focus are providers. When you look at the mix of providers -- I am not picking on physicians -- probably about 34 percent of my audits are really on inpatient hospital services. That fits with where the error rate is in terms of PERM, and I can get into more of that if we need to.

Right now I have about a little over 1,600 audits that are assigned out to 44 states, and we've identified an estimated $15.2 million in overpayments that we're anticipating from those audits.

What we've also found, one of the challenges of my traditional audits, if you will, is a lot of my algorithms are driven from using the MSIS data, which is a subset of the more richer states Medicaid Management Information System data. So that subset of data, in my opinion, is not as rich as it should be. There are a lot of data fields that it would be more efficient if I had in MSIS, but I don't have it right now. Plus I don't have the adjustments as timely as I would like from the state to be able to have more precision around my overpayment -- my activities in terms of audits. That's an effort we're working on. We developed a pilot of states -- I think a ten-state pilot -- where we're getting more data and we're testing it to see if we would have a better or a more robust outcome.

In the meantime, what I've decided to do is do what I refer to as collaborative audits. This is where I can bring the resources to the state through my contractors and use their MMIS data. So I can use their richer universe of data, bring my contractor support, and execute those audits in a more efficient manner, get a higher return, and usually turn it around much quicker than the traditional audits.

We're expanding our efforts with the collaborative audits because it's more efficient, so currently we're in discussion with 13 additional states to develop more of those audits. We did probably about half a dozen last year in the long-term care area, DME, home health, and the amount of time it took and the outcome was quite remarkable compared to the traditional audit where it can take almost two years from beginning to end of that audit.

The other thing I want to touch on are special field audits, and this is an opportunity -- what I refer to as "boots on the ground" -- where we actually will support the state in areas of high fraud, where they

need sort of a larger team of staff to work with them, whether that's sort of -- we've done that in California, Florida, and New York. It has mostly been in home health and DME, but the outcome has been quite remarkable where we can have -- I have clinicians, attorneys, a different mix of staff, and we can usually target the right kind of skill support to help us save in that way.

I mentioned the Medicaid Integrity Manual. I think it's a nice tool. It's Internet only, and it affords the state to have all of the information that we've sent out through bulletins and other information in sort of an easy-to-use layman's-term kind of expectations about performance.

I think that closes -- this pretty much sort of solidifies our efforts around provider screening, enrollment, and predictive analytics is on the horizon in terms of what we want to do with Medicaid in the future. I think the U.S. Small Business Jobs Act of 2010 requires Medicaid to be moving in the direction of predictive analytics. We know that that means a stronger partnership with the states because, in my opinion to use predictive analytics, you really need to be doing it or applying it to prepay claims and not postpay or close post pay. So that's just my personal opinion. It does not mean that's not where CMS will eventually go.

I think that closes it for me, and I will turn it over to Bill.

CHAIR ROWLAND: Thank you. From the federal view to the state view.

* DR. HAZEL: That's correct. Being a recovering orthopedic surgeon, he won't let me near that MacBook.

You notice she started to go in after me. I'm a country orthopedic surgeon from Virginia, and she's a country nurse from Goochland, Virginia. We're trying to keep the young ones out of these running battles.

It's a pleasure to be here this afternoon and to talk a little bit about what we're doing in Virginia. What I thought I would do first is, if I can learn to run this thing, just give you a little perspective on Virginia. You've heard the $366 billion spent, federal and state, and the nearly 60 million Medicaid recipients in the country. Our program, just to scale it, is to talk about what we do for program integrity. The scale is important.

We're $6.7 billion of the combined state and federal spend in fiscal year 2012, so that gives you sort of an example. We have about 800,000 Medicaid recipients at any one time over the last year. When you add the CHIP program for children, we're over 100,000. We're probably around 916, 917 now, which is significantly higher than it was a couple of years ago, and I think what you'll find later when I talk about PERM rates is our enrollment has increased dramatically in Medicaid and in some of the other social service benefits, and you'll see an effect of that later.

We are expecting going forward an increase under the PPACA of perhaps anywhere between 275,000 and 435,000 Medicaid recipients. We don't know exactly how many, but the more recent numbers are looking closer to the 400,000 range. And then we process about 33 million claims a year for medical services, and I would point out that in order to keep these people enrolled, we also have to check enrollment, do eligibility testing for about 1.2 million Virginians a year. So to get a perspective, we have 8 million citizens in the commonwealth, and we are looking at a little under one in eight right now.

With the size of this, obviously program integrity is a huge concern for us, and so we spend a lot of time and effort on it. We do extensive prepayment review with prior authorizations. We have a vendor that does that, and I think they perform about 400,000 of these prepayment reviews a year. We use Claim Check, which is a national software that looks at claims. I don't know all of your expertise, but when the

claims come in, is the documentation there, the coding correct. So we run them all through Claim Check, and then we also have several hundred audits in our own MMIS system. We know that, are painfully aware of that, because we just put in a new one last year. It's a lot of work there. So you do your prepayment review and then you do your postpayment data mining, and I think we audited 1,000 providers over the last two fiscal years. It is in-house staff, about 50, and we use four national firms that we've selected. The contractors conduct about 70 percent of our audits.

We identified about $40 million in potential overpayment, and we have something in Virginia called the Joint Legislative Audit Review Committee, JLARC, which audits different functions of government regularly, and they have confirmed this. They believe this is a fairly reliable number.

Now, being the size of our program compared to the national program, it would look like we're doing a little better in terms of the overpayment than a lot of places are, so we're pleased about that.

When we do find problems, there is an appeals process that's very extensive that someone can go through, but we generally are successful about 97 percent of the time in the appeals process. And I assure you that it's very thorough and very painful. They go on for a long time as we go through the appeals processes.

The next issue I'd point out is the PERM rate, the error rates, and we believe for our payments less than 1 percent, the number was 0.7 percent, which is below the national average. We would suggest that that number probably is a little optimistic. We're just guessing that for a variety of reasons we're probably not picking up all the improper payments, but we don't know that. This is the best we have. And 99 percent of what is missed on prepayment review we think we're getting in the postpayment review. So we put a lot of effort into these areas.

When we do suspect fraud, all of the errors and waste things are taken care of in the DMAS Medicaid process internally. When we suspect fraud -- and that would mean a pattern of bad behaviors, a cluster of something that's really unusual -- all of these cases are reviewed with the Medicaid Fraud Control Unit, and so their attorneys sit down with our staff, and we go through every single one of them. And if there is a concern about fraud, they are referred, and we referred 58 cases in the past two years, got about $25 million in reserve.

Now, one thing I will tell you -- and Lloyd and I agree -- it appears -- what my team said when we were prepping for this, they said, "Well, you can tell them that we do really well with our fraud unit in the AG's office, but don't represent that as being the norm for the country." This is apparently not. I don't know all the reasons because I'm not in the other states, but we tend to historically, no matter who's -- and we've had different parties traditionally in the governor's office and the AG's office the last few years. It has not been a real problem for us. They work collaboratively together. They review these cases in advance. And it seems to be working.

The MFCU has 48 full-time staff, or they did last year, and the General Assembly has approved hiring 25 more individuals to that office, and the cost of that is about $6.1 million if you're trying to get some handle on scale of what it is that -- how it fits. And so $6.1 million for MFCU in a $7 billion-a-year program is what you're looking at there, plus what we're spending internally.

Now, one thing we have learned, we participated voluntarily in the PERM eligibility study, and what was interesting to us is in 2009 -- I always have to put a disclaimer; that's before I got there, but don't ask what it's like since because I can't say it's any better. But our error rate on eligibility determination was 16 percent, we believe. Now, the tendency is -- and when the JLARC, I mentioned them earlier, looked at our

PERM rates, they said, "Well, gee, that's $681 million of Medicaid spending that shouldn't have happened." And as we talked them through this, we understand that that's not the case at all. A lot of these errors, or defined as errors, were things like incomplete numbers on applications, things like that. It was not a reflection of actually whether individuals were eligible or not. It was whether the paperwork was done.

And so to go back to my earlier story, I mentioned the ramp-up in adding a couple hundred thousand people in Medicaid. Another thing that has happened is we crossed last month 900,000 individuals in Virginia on food stamps. A couple years ago it was probably half that. And all that has gone up for a number of reasons, but our broker, our agent for determining eligibility, social service, their budgets haven't gone up, and these numbers have skyrocketed, so that tends to create some challenges in the system, and we think that -- we believe that the errors are largely due to just the volume and the fact that it's largely a manual process.

So what we're doing in Virginia is developing sort of an automated system for eligibility determination. We feel that is critical because we have had the increase thus far. Then with the PPACA results coming in, that's going to be a huge issue for us, and we hope to have that entirely automated, not to mention we're going to have to combine that with whatever there is in the way of a health benefit exchange eligibility system coming up in 2014. So we are working hard right now and investing a lot in trying to solve this particular problem.

Another area looking forward that we -- we are turning more and more towards managed care organizations in Medicaid and less Medicaid fee-for-service, and the question then is: How do you do program integrity through your vendors? The thought is just because they're capitated doesn't mean that the opportunities for fraud go away. So I think we're challenged, and we're looking for some direction in

terms of how to handle that.

Then the third bullet here has to do with our data-mining efforts. We have an RFP that's in the AG's office now, but we want to get away from the pay-and-chase and do more of the analytics, predictive analytics that are mentioned at a state level. And we do have an RFP ready to go out.

Now, quickly, there are really four areas where we interact with CMS. One is on the PERM rate, which we've talked about. It has been very educational. It tells us what we need to work on in our processes. I'm not sure that you can actually say that means recoverable dollars. That's something that the legislators can say, "Oh, boy, that's a bucket of money we can use for something else." But it isn't necessarily.

The second is the Medicaid Integrity Contractor Program which I think typically works well, but these are sort of federally defined contractors that come in and help us. The issue there is we have to train them in Virginia rules, and that's a problem. We feel that we would be better off if we could hire our own contractors or people that we're already working with to do more because we end up having to train them and that takes some time. But that is, I think, technical.

Recovery audits, I think you'll hear a little bit from Lloyd about the RAC. He likes them. I'm a recovering provider so I don't care for them too much. And in Virginia we have largely avoided that. We have to do it now going forward. We do worry about the head-hunting aspects with quotas and so forth. We don't know, but we have our concerns.

Then the fourth thing I would point out, which Angela mentioned, is the Medicaid Integrity Institute, which we think is a very high-value-added product and very effective and timely, and our staff has taken advantage of it and appreciates it very much.

So I would say that I think our relationships with CMS are good. There are some things that we would like to see done differently, but by and large, I think we're doing fairly well in Virginia.

* MR. EARLY: Good afternoon. It is an honor and a privilege for me to be with you this afternoon representing both the Ohio Medicaid Fraud Control Unit and our National Association of Medicaid Fraud Control Units. I want to thank the Commission very much for giving me this opportunity today.

Your staff, the MACPAC staff, has asked me to speak sort of generally about the role that Medicaid fraud control units play in the overall Medicaid Integrity Plan, and then more specifically about what has led to the successes of the Ohio Medicaid Fraud Control Unit in filling that role.

It's my understanding that at least some of you have very little exposure to a Medicaid Fraud Control Unit so I felt like we probably ought to start there.

DR. HAZEL: Well, that's a good thing.

MR. EARLY: But in order to do that, we've got to go back in time considerably, in fact, back to 1965. And as I'm sure most of you are aware, our Medicaid program had its genesis in Lyndon Johnson's Great Society. And as I certainly remember from my high school history classes, the Great Society was set of domestic programs that were focused on social reforms, the goals of which were the elimination of poverty and racial injustices.

And the health care initiatives with which Johnson's Great Society were associated focused on the availability of health care for the elderly and the economically disadvantaged, and ultimately then led to the Social Security Act of 1965, which under Titles 19 and 20 gave us our Medicaid and Medicare programs.

Now, all was fine and well, but as Congress would eventually discover, Title 19 of the Social Security

Act failed to include any program safeguards and failed to grant any specific law enforcement agency the jurisdiction and authority to combat fraud committed against the program.

So during the middle 1970s, Congress held a number of hearings, a series of these hearings, that were focused primarily on fraud in clinical labs and nursing homes. And one of the most notable pieces of legislation to come out of these hearings was the 1977 Medicaid and Medicare Anti-Fraud and Abuse Amendment, which among other things created our Medicaid Fraud Control Unit Program.

As originally devised, the program was voluntary and states could opt in or opt out at their discretion. But since 1995, Federal law has required that every state either have a Medicaid Fraud Control Unit program or receive a waiver from the Secretary of the U.S. Department of Health and Human Services.

Presently there are 49 states and the District of Columbia that have Medicaid Fraud Control Units with the State of North Dakota being the only state that is currently operating under a waiver. The program is a Federal grant program and each of the Medicaid Fraud Control Units is 75 percent funded by the U.S. Department of Health and Human Services, Office of the Inspector General.

Each of the MFCU – and that's the acronym, I'm sorry, MFCU or MFCU for Medicaid Fraud Control Unit -- each of the MFCU's is required to comply with the U.S. Department of Health and Human Services MFCU compliance standards, and they're subject to annual decertification by the Office of the Inspector General.

As you might suspect, the Medicaid Fraud Control Units are first and foremost creations of Federal law, and under 42 U.S.C. 1396, your Medicaid Fraud Control Units are granted the Federal jurisdiction to do three things. First, and perhaps most importantly for our discussion this afternoon, is they're granted jurisdiction to investigate and prosecute Medicaid provider fraud and fraud in the administration of the

program.

But in addition to that, each of the Medicaid Fraud Control Units also has jurisdiction over alleged abuse and neglect in long-term care facilities and the misappropriation of resident funds. And then to this jurisdiction, the Ticket to Work and Work Incentive Improvement Act of 1999 added the authority to investigate fraud involving other Federally-funded health care programs where the MFCU could establish a Medicaid nexus.

And then under this Federal authority, each state has enacted enabling legislation that grants investigative and prosecutorial jurisdiction to their Medicaid Fraud Control Units. I'm sure you've all heard the expression that if you've seen one Medicaid program, you've seen one Medicaid program, right? Because they're all a little bit different. And certainly our Medicaid Fraud Control Units are no different.

Forty-two of our MFCUs are located in their respective state's Office of the Attorney General, but seven of them are housed in other state agencies like the state police or a state Bureau of Criminal Identification and Investigation, or BCI.

And while some of the Medicaid Fraud Control Units have original criminal jurisdiction within their states, as a function of state law, others are required to refer these cases to local jurisdictions, or at least offer the right of first refusal to local jurisdictions. But these state-specific differences aside, Medicaid Fraud Control Units play an important role in CMS's Medicaid Integrity Plan.

First and foremost, we return more money to the program than it costs to operate us. During Federal fiscal year 2010, which is the most recent statistics available to us, it costs about $274 million to operate our 50 Medicaid Fraud Control Units, and those same 50 units in that same period returned over $1.8 billion to our 50 Medicaid programs.

Second, your Medicaid Fraud Control Units convict providers who are committing fraud, leading, as Angela referenced earlier, leading to the Federal exclusion of those individuals from all Government-funded health care programs. Again, during Federal fiscal year 2010, our 50 Medicaid Fraud Control Units conducted over 13,000 criminal investigations leading to over 1,600 indictments and over 1,300 criminal convictions.

And third, though it's arguably, I guess, impossible to quantify, the work of the Medicaid Fraud Control Units has a decided deterrent effect on would-be fraudulent providers.

And fourth and finally, we play an important role in CMS's Medicaid Integrity Plan that I think extends well beyond our role as a law enforcement agency. And our law enforcement efforts can only address aberrant behavior after it has occurred, after we've identified the aberrant provider.

But because of the nature of our work, we're uniquely positioned -- excuse me -- to identify statutory loopholes and regulatory shortcomings and we're obligated to make programmatic recommendations to our single state Medicaid agencies that help them curb fraud, waste, and abuse on the front end.

I'm extremely proud to report that the U.S. Department of Health and Human Services recently selected the Ohio Medicaid Fraud Control Unit as the number one MFCU in the country. In the last five years alone, we've investigated nearly 3,200 criminal complaints, posted over 550 indictments, 475 criminal convictions, 133 civil settlements, and recovered nearly $280 million for the Ohio Medicaid program.

And when you consider the fact that it costs the taxpayers in the State of Ohio right about $6 million a year to run the unit, I think you'd have to agree that we represent a pretty good return on the taxpayers' investment, returning nearly $10 to the Ohio Medicaid program for every dollar spent on the unit.

So what makes the Ohio unit a success or, arguably, what makes us different from other Medicaid

Fraud Control Units? As you can well imagine, I suppose, I've given that a great deal of thought over the course of the last year or so and we've discussed this at some length with representatives from our national association and with our entire management team.

And we keep coming back to the same four basic precepts. Number one is that we take great pains to hire the right people. You would think that because we're a law enforcement agency, it would be as simple as hiring prosecutors that have criminal law experience, or hiring special agents that have a law enforcement background.

You might think that, but I genuinely don't believe that you'd be right. In fact, we've found that quite the opposite is true. While there are certainly similarities to be found in the investigation and prosecution of all crimes, we recognize that there's a stark contrast between the skill set that it takes to investigate and prosecute violent crimes or traditional property crimes versus the skill set that it takes to investigate and prosecute white collar crimes, and more specifically, health care fraud.

White collar crime requires a very different mind set and a very different skill set, particularly with respect to our investigative staff. We tried for many years hiring retired law enforcement officers and police officers, but it hardly, if ever, worked out well.

So instead, today we're hiring almost exclusively college graduates, most of whom have graduate degrees. These folks have learned how to learn, they know where to go to find answers, they read and digest information very quickly, they write well, and they're creative problem solvers.

And in short, we've found them to be much more adept at handling complicated financial crimes and we've found that what they lack in traditional criminal investigative experience is more than made up by their education.

Number two is that we embrace what we call a strike force concept. I'm sure you've all seen the television show Law and Order. At the beginning of the show they say, dum, dum, the people are represented by two very important groups. These are the police that investigate the crimes and the district attorneys that prosecute the offenders.

And that is the traditional law enforcement model in our country. And while that certainly works very well when you're investigating violent crimes and traditional property crimes, what we've found is that doesn't work at all when you're investigating white collar crime, and again, particularly health care fraud.

So instead, what we do is we create interdisciplinary teams, or strike forces if you will, of supervisors, agents, prosecutors, and analysts who collaborate to bring about the timely resolution of criminal complaints.

When we assign a case, we don't assign it to an individual investigator. We assign it to a team and everybody on the team then contributes based upon their particular area of expertise. And what we've found is that with, like so many things in life, the whole is greater than the sum of its parts.

Number three is that we take a proactive approach to Medicaid program integrity. I think it would be easier for us to sit back and be reactive and wait for our single state agency, as an example, to refer providers to us for investigation. But instead, we've chosen to take a proactive approach and we actively seek to identify aberrant providers and create more and better and more efficient Medicaid program integrity partners.

We work collaboratively with our program integrity partners to craft data mining algorithms, and you've heard both these folks, William and Angela, talk about data mining and talk about the use of data to identify aberrant providers, and we work with our single state agency, your SURS unit, to create data mining

algorithms, run them against the paid claims data to identify those aberrant providers.

I've often said that there's plenty of pie to go around, and I think what I've learned is that as long as everybody gets a slice when they leave the table, everybody is only too happy to help us bake the pie. And we also engage in extensive outreach activities to better train our program integrity partners, to help them better understand what constitutes a prosecutable criminal offense, and to spread the word to the provider community, both for the deterrent effect that it has, but also to extend an invitation for all of them to become our partners in program integrity.

And fourth and finally, we take a holistic approach to Medicaid program integrity. We recognize that we're but one of many moving parts in this great Medicaid integrity plan, so rather than being isolationists, we choose to be inclusive.

We meet regularly with representatives of our single state agency, both the Office of Medicaid and with our Surveillance Utilization Review Section, with our Auditor's State's Office, with our Zone Program Integrity contractor and Program Safeguard contractors. We work very closely with our United States attorney's offices, FBI, HHS OIG, all to create better partners and to work collaboratively because what we've learned is that the secret to our success, at least, has been collaboration with our program integrity partners, and a recognition that Medicaid program integrity requires a team effort.

Again, I'd like to thank the Commission very much for the opportunity to address you this afternoon, and again, on behalf of the Ohio Medicaid Fraud Control Unit and our national association, I'd like to extend the Commission our offer of continuing support. Thank you.

CHAIR ROWLAND: Thank you very much, and I must say that's one of the most enthusiastic afternoon performances.

MR. EARLY: I like what I do.

CHAIR ROWLAND: I'm glad you do and I -- we have some questions. David, you want to make an opening comment and then we'll go on.

VICE CHAIR SUNDWALL: Yeah, thank you for your comments. We're clearly aware of all the interest in fraud and abuse and waste and appreciate your efforts to pay attention to the integrity of the Medicaid program. Please say hello to Peter Budetti. I taught him everything he knows when he worked in the House side. I was working in the Senate. Just kidding. He would tell you the other way around.

Mr. Early, I have a question for you. What is the benefit, if any, in your opinion of this move to create an Inspectors General of Medicaid to kind of elevate at the state level the attention to fraud and abuse? I know they've done it in Texas. We've done it recently in Utah. Is that just kind of moving the deck chairs or do you think that kind of a move brings necessary attention to our efforts to address fraud and abuse?

MR. EARLY: I think the latter, Mr. Sundwall, and while I don't personally have any experience with a state inspector general, because we don't have one in the State of Ohio, a number of states do, New York, perhaps most notably, among those. And I think there's a tremendous value to having an independent third party reviewing those claims and reviewing those processes and procedures, must as we see an effective benefit of having our auditor or state occasionally audit Medicaid providers.

Again, a disinterested third party, I don't see any down side to it. Dr. Hazel may disagree with me, but from my perspective, and again having no personal experience with it, it certainly seems to me to be a great idea.

CHAIR ROWLAND: Dr. Hazel?

DR. HAZEL: Mixed. I think what we have set up in the Office of Inspector General for the state this year, which is now -- we're trying to combine all the Igs from different agencies and figure out how it will work, and so it's not yet -- this decision was made. It's not yet operational. I worry when the internal audit function potentially gets separated from the agency. You need this sort of balance between independence and then folks who are actually understanding what's going on in the agency, because things change.

Now, the DMAS or Medicaid as a program is relatively -- I hate to say relatively simple compared to, say, behavior health and some of the things we deal with. You do certain things over and over again, it's high volume, and may be more amenable to an outside IG.

But if you've got the program in place, this is the deck chair on the Titanic thing. I don't know. It's got to work and if it works well, I think you could structure it any number of ways successfully.

CHAIR ROWLAND: Okay. Trish?

COMMISSIONER RILEY: Well, Caroline, I think that was a tough time slot and it was a tough topic, but it's a great panel. We really got quite an overview about -- it brought me back to my days long ago as a Medicaid director when we had a Director of Service who was a six-foot-three nurse, older woman. I was a kid. She scared the hell out of me. She was so successful with like a staff of three. It was incredible about her ability and it's brought me back there.

It does strike me from the conversation and from the paper that what we need is almost a chart, and I'm not a visual person, but who does what here? Because I think the big issue and the attraction to this issue of fraud and abuse in the current debate suggests we need a baseline. How big is the problem here?

You know, what percent of fraud and abuse compared to all the spending in this program, how big

is this problem? Who does what? How do they all interrelate? And what's the return on investment? And I think we, as a Commission, can be value added as we sort our way through that, particularly now with the emergence of IGs and in many, many legislatures there are program review initiatives and audits that add yet another layer to all of this.

So I think we need to figure out who does what, how it works, what's the return on investment. I think both of you, Bill and Lloyd, talked pretty specifically about the return on the fraud units, not so clear on the over-payments, Angela, when you talked about we've recouped $15.2 million.

But what does it cost us in administrative costs, including appeals? Because the process of over-payment is a long one and I don't recall ever seeing an over-payment that wasn't appealed. So what are the costs here? And I think that's pretty significant.

And a third question I'd want to ask you all is, as we move to 2014, the PERM issues and the error rates as we change to simplify Medicaid and to move to a much more streamlined eligibility, we might somehow make some kind of change in how eligibility for food stamps and all the other programs are connected and coordinated. What might happen? Might we see our rates actually increase as we simplify Medicaid?

CHAIR ROWLAND: For anyone on the panel.

DR. HAZEL: To work backwards, on the eligibility issue, we've spent a lot of time on it and I think the good news is I think HHS recognizes that we cannot have the isolated systems that we've had in the past. What has historically happened is if Medicaid money was used to pay for a system, it was a Medicaid system and you can't touch it.

What we were able to do this summer is work with CMS, and they agreed and then subsequently

OMB concurred, that if we did use purchase technology or a system through, we're using Medicaid administrative funds, that it could be used for other purposes of multi-tasked later, provided that what you're using it for is contributing as well.

And that's a huge plus for us because you can bet that we also last year determined eligibility for 1.2 million SNP beneficiaries. How many of those are the same people? And not only does it work for our social service, we know from medicine the more times you do the same thing, the more likely you're going to get mistakes made in it, the allergy list, things like that.

So having the shared technology and the authorization -- one of the issues we're running into now is we had data that may have been collected on a social service application, but because it has been run through the Federal process, there is some limitation on how we can use that data. There's concern about that we're trying to work out.

So we need at a Federal level to have the rules such that when we have information that we can use it, we want to protect privacy, we need to deal with the security issues, but there are times when the sort of the artificial barriers limit your ability to do what should be logical.

MS. BRICE-SMITH: Let me touch a little bit on the audits and the issue about appeals. When we at the Federal level do or perform the audits, we basically say to the state, These are our findings and we want the Federal share back. So in terms of the appeals process, that obligation goes back to the state. So we basically report out.

At the beginning of the audit, we vet it with the state so that they know it's coming, they know what we're looking at. And we also don't want to step on the toes of law enforcement if they have actually got a case going against that provider. So after all of that is said and done, then at the end of the day, we ask for

the Federal share back if there are over-payments.

In terms of ROI, my budget basically is $75 million a year, $75 million a year. Now, when you look at what I do, though, with that money, it's been a little bit challenging. In fact, I'm working on models right now of how can I address the technical support I provide to the state in a hard number? How do I address that MII with 22 courses and all that training?

You know, it's intangible. It's not easily -- I can't really get there. How do I count all that technical support to the Department of Justice with statisticians and extrapolation models when they're going for a settlement? I don't have an easy way to capture that right now, so it's not a pleasant ROI just to look at my pure audit.

But, you know, clearly there's value that people have recognized, that we recognize. We're just trying to figure out how I can better convey that in a way that seems reasonable to people and people understand what I'm doing.

DR. HAZEL: Could I?

COMMISSIONER RILEY: Is there a baseline pre the institution and post the institution about what state activity was? Do you have any sense?

MS. BRICE-SMITH: Not a whole lot. I mean, we are doing -- we have instituted now sort of satisfaction surveys where we're trying to quantify how productive or did they use any of the information from those settings and what did they do to give us examples. So that's part of the story we're trying to tell through those anecdotal or that quantification through surveys.

COMMISSIONER RILEY: Okay.

DR. HAZEL: If I may just to follow that and then go back, our team tells us they're valuable,

they're helpful. I can't quantify and I don't think anybody had a baseline where we can go and do a before and after. But the team and the experts feel that they're useful.

I wanted to go back to, I think, your first question, who does what and how big is the problem. I think that for us, it may be a little bit of wishful thinking at times. We know there's fraud. We know there's abuse and we know there's waste.

And as a physician who has had to do coding and documentation, we were an orthopedic practice and a fairly large practice, and so quarterly, we audited charts on each of our physicians to see how accurate their coding was. And we did training.

And I will tell you that I could rarely get better on my E/M codes than about 80 percent because of the documentation requirements. It's an absurdity, to be honest with you. It's very complicated. And so, you could easily look at what I did and on any given quarter, you could say that 20 percent of the time I was billing fraudulently, and there's no intention of that.

It is very complicated to do the documentation. And so, that's an issue that I think needs to be worked out, and particularly as we go to alternative payment structures. I think we are all recognizing more and more that the Federal payment formulas, the RBRVS, DRGs really aren't -- we aren't getting what we want in the system. So as those change, that will be a difference.

But I don't know how to measure the amount of fraud we have, but what I can also tell you, it would be useful to have a number we all agree on because I think that budget balancers, as we've all been, are optimistic that there's just this pot of gold out there if we can just find it, and then it's going to solve all of our problems. And I don't know that that pot of gold actually exists.

CHAIR ROWLAND: Thank you. Patty?

COMMISSIONER GABOW: I actually have four questions and one of them springs right from what you were saying, Dr. Hazel, about how complicated it is. It would seem to me that if one looks at the root cause of this, now some of the root causes are bad people. Okay? But I would say the bigger root cause is it's an incredibly complicated system with thousands of rules, and that -- so my first question is, wouldn't the root cause of this be simplification of the billing system?

And sort of a spin off of that is when each of you find a recurrent issue, is there a response to go back and simplify or clarify the root problem that makes people make that mistake? And isn't ICD-10 going to make us all scream more about this? So that's my first question.

The second question is, in your experience, can you find areas where it's more likely to be a serious issue and maybe that's where to focus on? So is it more common in for-profit and public programs? Is it more common in big enterprises or little enterprises? I don't know the answers, but it seems like some sorting might get a focus.

My third question is, when you do the audits, how frequently do you find under-payments as well as over-payments? And are those paid back?

And my fourth question is, one of the things that was said by the initial presenter is about attempting to reduce the burden on providers. And I think that's important because there's a cost to providers that are not included in any of these costs that reduce the ROIs substantially.

So I know those are a lot of questions, but I think they're sort of core issues.

MR. EARLY: Go ahead.

DR. HAZEL: If I can --

CHAIR ROWLAND: Coordinate here.

DR. HAZEL: If I can work back, when I mentioned my error rate on coding as a physician, that was under and over and I was about equal. So I would under-code and over-code and I can't ever recall being -- somebody brought back to tell me they owed me more money. We don't tend to look for that, and so I don't -- there may be cases where we have found systematic under-payment and corrected that. I'm not aware of that. That would be somebody else's call.

I can't say that I know that fraud follows organizations or size, things like that, but what I do see in certain areas such as group homes and some of the therapeutic daycare and foster care, we see a couple of things that happen.

Number one, we see a lot of providers who just don't understand how complicated the program is and then they get into trouble and they ask questions. I just had a state senator calling me about somebody recently, and the folks, I believe, were good people, but it was almost like this, Do I need a lawyer now?

And it's, boy, you're in over your head here. And I think that a lot of -- some of the -- there are, at least in our state in some areas, particularly around Richmond, there are probably a lot of providers who got into the business intending to do well, meet a need, be profitable, and they just got in over their head. I think that's something that we have to be careful about. Those would be sort of my comments. Go ahead.

MR. EARLY: I guess I'd very much like to address the first part of your four-part question if I will with this notion about are we more likely to see these problems with large providers versus small providers, and I think it's a misconception to think that there might be a difference based upon the size of the provider.

But rather, more likely a differentiation based upon the category of service. And certainly what we

have found in terms of vetting out fraud within the program is that we're more likely to see fraud in those categories of service where there are fewer barriers to entry.

In other words, it's as the good doctor will attest, it's extremely difficult to get a license to practice medicine. That's not something that all of us can do. And as a consequence, a very small percentage of people are ever going to qualify to provide those services.

On the flip side of that, virtually anyone can qualify to be an independent home health provider in the State of Ohio, and as a consequence, because of the lack of barriers to entry within that program, we're seeing more and more fraud in those categories of service.

In addition to that, I can't help -- and I'll apologize for this because it's a little bit funny -- but I look back to the 1930s. There was an infamous bank robber by the name of Willie Sutton and the FBI chased Willie halfway across the country and when they finally caught up with Willie they asked him why, you know, why did you rob banks? And, of course, Willie, quite famously, said, Because that's where the money is.

And I think what we're seeing nationwide, as I talk to my counterparts around the country, is a move away from institutional care and towards home and community-based services. You know, we all agree that it's less expensive to provide care to someone in their home than it is in a nursing facility, as an example, and certainly their quality of life is better in their own home than in a facility setting.

And as we see this shift in funding away from institutional care and toward home and community-based services, we're certainly seeing more and more fraud in those home and community-based services, most notably home health services.

CHAIR ROWLAND: Mark, I think you were next.

MS. BRICE-SMITH: Since you touched on item one, I'll defer to that one and just go to two, three, and four. You asked about areas of seriousness, and what we've tried to do is we looked at the PERM, the areas of the PERM rate that seem to be driving the errors. So it turned out to be inpatient services, long-term care, home health.

Then we looked at what we knew about some of the issues around prescription drugs and we added the fourth focus area of prescription drugs as areas of focus that we want to encourage the states to work on in their audit activities and driving the error rate down. The error rate, as I mentioned, just recently was reported to come down 8.1 percent.

The third issue is how frequently we look at under-payments. The statutory provisions around DRA in the Medicaid Integrity Program did not require us to address under-payments in any fashion.

That said, when we started looking at the audits, and if I got an audit report back and the contractor indicated that there seemed to be evidence of under-payments, even though I don't get all of the adjustment information from the state, I will personally write a letter to that state Medicaid agency director and say, Please be aware, we believe that there may be some under-payments, and we provide the data and information.

So we leave that up to the state to mitigate in terms of adjusting claims or working that out with the provider.

The fourth item was reducing burden to the providers, and what we've tried to do in that realm, and I think you can see it reflected also in the Medicaid Recovery Audit Contract reg is there's the expectation of coordination of audits.

We know, on the MIC, the Medicaid Integrity Contractors side, that we are vetting all of our audit

activity with the state for eight weeks and law enforcement, Federal and the state. So for eight weeks, we basically stand down and wait for them to tell us, Is there a problem? We're moving forward. So forth.

The expectation with the advent of the RACs is the same thing in terms of coordination. We know that that's going to be a challenge and what we've tried to do is provide some mechanisms. In fact, we're working out the agreement right now with Department of Justice and OIGs so we could all be on the same page about vetting it with the Medicaid Fraud Control Unit, letting that mean -- also vetting that with the FBI and how would that work and how would that be communicated. Also, the MICs are involved.

And then how about the Medicare contractors, the ZPICS and the PSME? That's a lot of activity to coordinate. So we're trying to make sure they have the tools, they have that information if they want to use it. In fact, we're going to pilot test the use of the data warehouse, if you will, that will allow them to see what's going on on the Medicare side.

If it's a Medicaid activity, the Medicaid RACs, so that they can have that information and feed into whether they should move forward with that audit at that point in time.

CHAIR ROWLAND: Okay. Mark.

COMMISSIONER HOYT: Yes. Until Angela mentioned drugs five minutes ago, I hadn't heard anything about this. This could be going on, but I didn't read it in the prep material or her it until now, so I just thought I'd mention it.

I'm an actuary. I work for a consulting firm. About half of what we do is advise States what to pay managed care organizations to certain Medicaid recipients, and some time ago, the other people working in the group, some pharmacists, people in informatics, data analytics, and so we typically collect all the pharmacy data in a State, especially from all the managed care contractors. They can do this if it's carved

out. You can do it for a fee-for-service program.

It's not a trivial task, but in the end of the day, the ROI from the work we've done is about 100 to one, depending on the size of the State, where you would write code to bounce the pharmacy encounters or claims off of that would, you know, just check, and you mentioned all the States are different. Do they have a preferred drug list? Do they have a formulary? Do they have a MAC list? Are there different levels of rebates in place? Are the drugs age appropriate, gender appropriate? Are they contraindicated by the condition a person's got, other drugs they're taking?

You can come up with a pretty robust set of edits eventually and we've seen -- and if we're advising a State would pay an HMO, we'll go through all this data and then just take it out of the database and present it back to the plans and say, here's everything we've found. We're just not going to pay you for this. This doesn't make any sense to us. Would you care to explain why all this was in your data?

And we do other things, too, kind of around clinical effectiveness overall in all the data, but that's -- the pharmacy edits are about the most bulletproof sort of edits or take-aways that we've done. I don't know whether that's fraud, abuse, waste, or whether it matters, but there's certainly a number of States that are doing that now to strip that money out of the funding stream.

CHAIR ROWLAND: Okay. I have Sara, Andy, and Judy. Sara.

COMMISSIONER ROSENBAUM: Thank you. That was really an excellent panel. I have a couple of questions.

I assume that an overpayment does not fall into your territory unless there's evidence of a False Claims Act conduct going on. Any overpayment is considered to be a fraud and abuse matter? No. There is --

DR. HAZEL: No. No.

COMMISSIONER ROSENBAUM: It's just a narrow, a narrow range of overpayments.

DR. HAZEL: When I test, if there is an overpayment, we tend to recover it. A lot of that's just handled internally and it can be appealed and so forth. The issue of deciding when it's fraud as opposed to an error -- we allow for errors, but that's when, in our State, our folks who are specialist physicians, nurses, administrators, whoever it is --

COMMISSIONER ROSENBAUM: Look for a pattern.

DR. HAZEL: -- that's looking at it that we pay to look at the claim and say, there's a problem with this claim, if there is a question, then we'll sit down with our counterparts in the MFCU and say, all right, is this -- do we think this is an error? Do we think this might be symptomatic of fraud? If it is, it goes to them.

Now, one of the, I think, points of tension between us and the MFCUs is that we would like to see them pursue more, but they are recognizing limited resources and they are saying, you know, the likelihood that we are going to get this and get any recovery makes it not worth chasing. So there are -- we would say that there probably are some resource allocation issues on that end that we could, you know --

MR. EARLY: Sure. Let us not forget that if I walk into a bank with a ski mask and a shotgun, there is little question in anybody's mind that a crime is being committed.

COMMISSIONER ROSENBAUM: Right, and --

MR. EARLY: And certainly every law enforcement agency --

COMMISSIONER ROSENBAUM: -- much more ambiguous --

MR. EARLY: Sure. Absolutely. Fraud is, by design, difficult to detect. The most challenging

thing for those of us in law enforcement is proving criminal intent, and obviously the difference between an overpayment and a fraud is that provider's intent. What was in their heart at the moment that they submitted the claim?

And typically speaking, we work very well with our single State agencies to identify things that are indicia of intent. In other words, what sort of work has the single State agency done in terms of provider education regarding that specific kind of claim? And if we can demonstrate that the single State agency has properly educated the provider, that they knew that what they were doing was wrong and that ultimately their false claim was material, that's when we look at it criminally.

COMMISSIONER ROSENBAUM: And my other question is, can you comment at all on why so few States have taken the False Claims Act incentive? Is Virginia, or are either of your States a False Claims Act State now? If you are, why? If not, why?

MR. EARLY: Do you want to start?

DR. HAZEL: You start.

MR. EARLY: I will start. Ohio does not have a Deficit Reduction Act compliant False Claims Act. It has now twice been proposed to our State legislature and both times has died.

DR. HAZEL: Before my time.

COMMISSIONER ROSENBAUM: It is sort of striking that only 14 States at this point have a Deficit Reduction Act False Claims Act structure, and I do not know, Ms. Brice-Smith, whether this falls under your jurisdiction or –

MS. BRICE-SMITH: No. It falls under the Office of Inspector General --

COMMISSIONER ROSENBAUM: So we are aware that --

MS. BRICE-SMITH: -- the 14 and we know that there are some States that didn't meet the criteria, but I don't have any analysis to --

COMMISSIONER ROSENBAUM: I'm not sure that I'm surprised at the low number, but I was interested in why.

CHAIR ROWLAND: Then, Judy, you're on.

COMMISSIONER MOORE: Can you, Dr. Hazel, and you, Mr. Early, say a few words about -- or, actually, anybody can comment on this -- I wondered about how you find the process of coordinating with Medicare on these same kinds of issues, if you have good working relationships through CMS or the contractors or how that works.

And then I'd also like for you to comment on the differences between the kinds of activities you undertake for program integrity with fee-for-service providers and managed care providers. So --

MR. EARLY: I'd be happy to start. First and foremost, I'd like to say that our relationship with the folks who deal with program integrity in the Medicare program is excellent. In fact, we meet monthly with the representatives of our Zone Program Integrity, program safeguard contractor. Their obligation under their Federal contract is to identify aberrant providers and refer those to the U.S. Department of Health and Human Services Office of the Inspector General. I get copied on every one of those referrals. We share our active case lists with them every month to make sure that we are stepping on one anther's toes. We work very, very closely with FBI and HHS OIG in Ohio, again, to conduct joint investigations, and again, to make sure that we are not wasting resources by looking at the same person twice.

With respect to your second question about fee-for-service versus managed care, when I was a very young agent and had a lot more hair than I have today, people told me that managed care was the panacea,

that once managed care came into Ohio, we wouldn't have any fraud in our Medicaid program, and nothing, of course, could be further from the truth. And the reality is that what we have found is that investigating fee-for-service provider fraud and managed care provider fraud is no difference at all. It's exactly the same. You see the same exact kinds of provider aberrant behaviors and you see the same kinds of provider fraud schemes.

DR. HAZEL: I would just say, we are setting up a unit. We are putting four people in to work with the managed care organizations, since that is a growing part of our business, and what we are trying to be is really collaborative with them because they have their own interest in ensuring that there is no fraud in these things. And so the idea is to share what we have, use what they have given, the tips that we have picked up along the way. So I would -- Lloyd and I would give you pretty much the same story there.

COMMISSIONER MOORE: And there's no less attention, right. I mean, you don't have to spend less time --

DR. HAZEL: I think I would say that we historically probably have spent less time, but probably shouldn't have, and we are refocusing. We're just setting up that unit now of, as I say, a four that will be charged specifically with helping the managed care organizations. You know, it's hard to know what you don't know, and so as we get started in this, we don't necessarily know exactly what we're going to find there.

MR. EARLY: There was one other point I wanted to make in response to your first question, and that is that some number of years ago, the Centers for Medicare and Medicaid Services established as a part of the Deficit Reduction Act of 2005 a Medi-Medi pilot project, and there were ten States originally included in that project. Ohio was fortunate enough to be one of them. And essentially, what they did is they

provided funding to the program safeguard contractors to create a database that had Medicare and Medicaid claims for providers in that State and used data mining algorithms to identify aberrant behaviors within both sets of data, or to take a particular aberrant scheme from Medicare claims and apply that to the Medicaid claims, as well. And in Ohio, at least, it's been wildly successful, and I know that the Patient Protection and Affordable Care Act includes funding to take that program nationwide to all 50 States.

DR. HAZEL: You enjoy this so much, we ought to send more fraud to Ohio just to keep you going.

MR. EARLY: Bring it on.

[Laughter.]

CHAIR ROWLAND: Let me ask, you were talking about identifying provider groups that are newer and less likely to have credentialing, and obviously one of the areas that we're concerned about is the expansion of home and community-based services through Medicaid, but it also then has a Medicare component to it. Can you talk a little bit about, instead of -- how you're looking at that particular set of services and what some of the challenges there are?

DR. HAZEL: Carefully. You know, for us, the home and community waivers, the consumer-directed programs -- that people really like them. There's a lot of -- it is definitely -- I don't know that we've got a handle on -- what we have tried to do, separate out the fraud from the value-added of the service. And we do worry sometimes that the services may not be adding the value they're supposed to be adding when they're delivered sort of out of sight of the normal sites or the normal settings and so forth. We are moving more towards the coordinated care model so that individuals will have a care plan and that there will be goals in it, and we're trying to deal with it on that side, just on the terms of the value of care.

In terms of the fraud piece, it's -- trying to wrestle that topic is something that I'm not sure that we've got all the answers to, at least in Virginia.

CHAIR ROWLAND: Like in Ohio.

MS. BRICE-SMITH: At the Federal level, what we have observed is there are some real issues, for example, we've identified with personal care services, and what we're trying to do with that is try to look at States that seem to have better practices around addressing the issues and showcase that through our Medicaid Integrity Institute in terms of teaching and information.

Then the other thing we're doing is shifting and doing some actual audits involving personal care services based on a lot of the information we see from the litigation cases, for example, where we know that there are some weaknesses that need to be addressed.

MR. EARLY: When I was a young, wet behind the ears special agent, first hired into the Medicaid Fraud Control Unit in 1994, we had a total of 26 provider fraud complaints concerning home and community-based services providers, and that includes things like home-delivered meals and home modifications, but the vast majority of them are home health. Last year, we had 264. It's literally been a meteoric rise. In fact, this year, 55 percent of my active caseload is home health providers, both agency providers and independent providers.

And I certainly don't know what the answer is, and I'm glad to hear that CMS is looking at it, but one of the things we have seen that represents, in my estimation, at least, a terribly alarming trend, is an involvement of the consumers in these schemes to defraud. And what we're seeing is consumer kickback arrangements, where the consumers recognize that their plans of care have value. And so when they're interviewing prospective providers, they're doing it in such a way that Dr. Hazel comes in and I say, Doctor,

you want to be my independent home health provider. You only get on the ticket if you're willing to kick back to me half of what you make from Medicaid. And so what we find ourselves doing is convicting a lot of home health consumers as well as the providers, again, in these kickback arrangements.

CHAIR ROWLAND: Burt, I know you had a question.

DR. HAZEL: Could I address the barriers to entry question?

CHAIR ROWLAND: Sure.

DR. HAZEL: I think that Lloyd has it exactly right. The trick is, though, is I'm not sure we want to create a lot of barriers to entry. You want to have people who are competent and capable, but if you're going to have any sort of Medicares, one of Adam Smith's principles is no barriers to entry. I think one of the reasons you look at sort of the stenosis of the delivery system in medicine is we do have so many barriers to entry that it's very difficult to get a lot of reform in delivery. So that's a challenge.

So if you're going to address that, I'd be mindful that there are advantages to having fewer barriers as well as problems. But I do think, and again, I'll repeat, I do think we see a lot of providers who get in probably with good intentions but get in over their head, and then they're in trouble before they know it. And even with high barriers to entry, I keep looking at that error rate that I had on my coding, and Lloyd could come along and say, you've been doing this year after year after year, Hazel. That's fraud. And I'm saying, no, I'm stupid. I can't do it. This is too complicated.

CHAIR ROWLAND: Thank you.

Burt.

COMMISSIONER EDELSTEIN: I'm wondering if the panel could share their thoughts about a possible conundrum here. We had earlier talked about provider willingness to participate in Medicaid or to

take new patients, and so the potential conundrum is that a clear goal of fraud and abuse work is deterrence, and I wonder to what degree providers regard the entire work around fraud and abuse as a factor deterring their participation as providers.

MS. BRICE-SMITH: We have spent a lot of time in the agency, as you can probably imagine, the whole balance of access to care and services versus maybe the perception that we are chilling the health care industry with our activities in PI. I think what we've tried to do is persuade people that if we ferret out really the misspent dollars, there's more revenue and dollars to do a lot of the things that we are all are valuing and want to see done in our health care system in terms of improvement or in terms of quality. So I think we all struggle with that daily when we have to deal with issues around fraud, waste, and abuse, but for the most part, I sort of view it as if they get to my level of attention, then there's probably something there that I need to be aware of to address and just kind of deal with it that way.

DR. HAZEL: If I could, I'll put on the provider hat. The complexity of billing, even in the private sector, is such that you're looking, at least in an orthopedic practice that benchmarked and was well run of two or three individuals handling billing per doctor, and so you look at a tremendous cost of that. And I mentioned we were auditing ourselves quarterly to try to ensure that we were -- and that was mainly around Medicare, not Medicaid.

I know that with the advent of the RAC and things like that, there were a lot of providers who just said, you know, I don't want this. Now, the fact is, is you're kind of stuck in a way, depending on what your practice is and where you are. You don't have a lot of options to go if you're on the Medicare side of things.

It's hard for me to know this without some sort of an instrument, but we do know that the

participation rates in Medicaid are generally lower, as are the payments. So is it the payment and the general hassle? How do you segregate out which is the fear of fraud? I think we've got a little bit past that, but somehow, the documentation requirements in Medicare and Medicaid have got to be rationalized, because I think what you're saying is it's a game that gets played. You know, they teach us how to code and you can get the computer to put the bullets in and you get three of these and four of these and something and you get a level four. Well, the game just goes on and on and on and it's so wasteful that it needs to stop.

MR. EARLY: I think Dr. Hazel makes a great point. In the State of Ohio, we have roughly 2.4 million Medicaid consumers and somewhere in the neighborhood of 90,000 Medicaid providers, and what we've found as a Medicaid Fraud Unit, between the work that we do and our Federal counterparts do, we're convicting somewhere in the neighborhood of 150 to 200 people a year of Medicaid provider fraud in the State of Ohio. And while we certainly like to believe that has a deterrent effect, we certainly have not seen a shortage of folks who are willing to be Medicaid providers. In fact, quite the contrary. There seem to be more than we know what to do with.

And certainly while there are geographic exceptions to that, for instance, in the unglaciated Southeastern portion of the State of Ohio where the population is fairly sparse, it is difficult to find providers, particularly in particular categories of service like dental providers. But for the most part, in the major metropolitan areas where we have large and healthy populations of Medicaid consumers, we haven't seen any shortage of providers.

CHAIR ROWLAND: Richard.

COMMISSIONER CHAMBERS: Angela, it is good to see you. It's been a while. When I was

actually a colleague at CMS over in Medicaid Managed Care, I used to push for program integrity focus, and I used to always think, well, with managed care, it's somebody else's problem. You write that check every month. I was told by Judy Berek, if you remember, years ago, she was head of Program Integrity at CMS, and she said, if you think that way, you're losing a lot of money.

Now, as a managed care organization executive, I just would like to encourage how you can work with managed care organizations, with more than half of Medicaid beneficiaries getting their care in managed care organizations. It is a struggle, and I wonder how the Institute maybe can be expanded to be able to educate managed care organizations and opportunities to work with CMS and local law enforcement folks, and Dr. Hazel, you mentioned that as you have worked with your plans in Virginia, is trying to figure out how to do that and to engage them. So I would encourage you. I think it's a big thing. And again, as a very large organization that serves almost 400,000 Medicaid beneficiaries, even we struggle with trying to get the infrastructure and the knowledge to be able to do that.

The other thing just as a general comment is discussion about the fraud in home and community-based services. Just a cautionary note is the issue of being careful not to throw the baby out with the bathwater. As many fraud issues are identified, seeing the delivery system on the ground is the additional free care that's provided by family members and others that are personal care attendants.

California is going through right now its elimination of the adult day health care program, which for years they've struggled with fraud in the program and never quite could figure out how to do it, so they solved it by eliminating the benefit completely, which was supposed to be December 1. They did a settlement and it's been extended a couple of months. But the struggle instead of finding solutions to either addressing the fraud or changing the program of throwing it out.

And former Governor Schwarzenegger for years talked about the personal care benefit and had tried to slash it and almost eliminate it a number of times, again, for the same reason. It's sort of broken, so let's just eliminate it, and that's -- we just have to be careful as those kinds of unintended consequences to programs that really do serve very vulnerable populations.

CHAIR ROWLAND: Other questions?

[No response.]

MEETING DISCUSSION AND WRAP-UP

* CHAIR ROWLAND: Let's look a bit at the outline and see if this conversation has helped us go forward and what we would like to do with this topic. Our panelists have clearly given us a lot of food for thought as well as kept us wide awake through this late afternoon session, so we commend them on that.

Any other comments on the chapter, though, from Commissioners?

[No response.]

CHAIR ROWLAND: Well, with that, I will thank Caroline and thank our panel. It has been very informative, very helpful, and I think will certainly be a topic that we will need to address as a Commission and this has given us a really good start at putting the pieces together and I wish you all luck back in your respective positions and we will be back in touch with you, I'm sure, as we move forward on this issue.

And now we can excuse the panel, but we can ask any of the diligent folks that are sitting in our audience if they have any comments or wisdom they would like to share with the Commission. We would be glad to entertain that at the microphone.

If you would also please tell us who you are and then talk to us. Thank you.

PUBLIC COMMENT

* MR. COONEY: Sure. Sure. Hello. My name is Patrick Cooney and I'm here today representing the interests of the American College of Nurse Midwives. And really, I just wanted to be here to thank you for your focus today and in your various sessions on access to care, and particularly the sessions that you had earlier, the two briefings that you had on access and then the second one that you had to focus on pregnancy and maternity care. We really appreciate the focus in those areas.

I wanted to bring up one particular area that ACNM has been focused on in recent years under Medicare in the belief that it might help you on the Medicaid side as you look at accessing -- beneficiaries accessing services, and that's in the last year, during health care reform, one of the provisions that was included addressed the reimbursement rate for Certified Nurse Midwives. You may be aware that Certified Nurse Midwives had previously been reimbursed at 65 percent of what similar health professionals received under the Medicare program. Now, that 65 percent represented when the Certified Nurse Midwife billed independently and separately to the Medicare program. If they were working within a group practice and a physician practice, the practice would bill at the 100 percent rate, even if the Certified Nurse Midwife was providing the service, and that's because the physician billed the service incident to.

So as part of health care reform, there was a provision to address this, and we were thankful that the Congress enacted a provision to bring reimbursement up to 100 percent under the Medicare program, and we saw a chart earlier that there are certainly a number of births to disabled women within the Medicare program. But then, also, Certified Nurse Midwives are providing well woman services to women throughout the Medicare program. So I think this increase in reimbursement and recognition of the quality services that Certified Nurse Midwives provide will pay dividends in the Medicare population.

Now, you transfer that to Medicaid and you look at the situation today under Medicaid, about half of the States are paying Certified Nurse Midwives equally to their physician counterparts. About half the States pay at 100 percent rate. But the other half of the States are anywhere between 65 percent and 100 percent.

I thought it was interesting, the report earlier today by Kaiser which looked at how can we encourage more practitioners to get into serving the Medicaid population, and thought it was interesting that it didn't look like there were a whole lot of ways to incentivize practitioners who weren't delivering Medicaid services to get in. You don't have that situation with nurse midwives. They are in, participating in the Medicaid program. So the challenge for the nurse midwives is being able to expand and serve the growing population and the expanding population that you've been charged with expanding into Medicaid in the coming years.

So we would encourage you, that as you're looking at Medicaid, be cognizant that the reimbursement rates do impact the ability of the nurse midwives to take on additional patients. Hopefully, we're hoping that States will follow the lead of Medicare and follow suit and increase those reimbursement rates.

We really appreciate your focus on this and we look forward to working with you in future meetings and as you work on your comments to Congress and the States and we would love to focus our energies to help you as you look at maternity care. Thank you.

CHAIR ROWLAND: Thank you very much. As I hope has been clear during our earlier discussion today, the issue of care for pregnant women and maternity care is a main issue that we intend to take up, to look at. We have become very aware of the role that nurse midwives play through the

membership on this Commission and we appreciate your comments and really do think that scope of practice and reimbursement rates, especially around this critical set of services, as well as around primary care more generally, is something that we really need to look at and focus on as a Commission.

So today, we really did start by looking at access and quality. We're going to move on to look at children's care, pregnancy-related care. We had some program integrity discussion here, but tomorrow, we're going to move on even more broadly to look at some of the issues with regard to payment and financing, and all of these things, I think, are really critical to making this program, Medicaid and CHIP both, work effectively for the populations they're intended to serve and for being fiscally responsible about the way in which we provide services and direct the care that's needed.

So this has been a good start on getting our house in order for the analysis and work we need to do for our upcoming reports and for our continued consideration. Tomorrow, we'll continue that, but we do appreciate having a public comment today. We look forward to having more public comments and we will adjourn for today and reconvene tomorrow. But we thank both the audience and I thank the Commission members and all the panelists who share their time and expertise with us. Thank you.

* [Whereupon, at 5:00 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, November 18, 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, November 18, 2011
9:23 a.m.

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

LU ZAWISTOWICH, ScD, Executive Director

P R O C E E D I N G S [9:23 a.m.]

CHAIR ROWLAND: Welcome to the second day of our MACPAC meeting. We've gone from rain yesterday to cold weather today, and hopefully we can get this room to be a little warmer than it has been. But I think the discussion will be a warm and fruitful one, I hope, and we're starting with a very warm and fuzzy issue, which is the basic financings of Medicaid. So I'd like to turn to Jim Teisl of our staff to key us up. This is Tab 5 of the briefing book for the Commission members.

BASICS OF MEDICAID FINANCING

* MR. TEISL: Thank you and good morning to everyone. As Diane mentioned, we're going to start the day with a couple of sessions devoted to issues related to Medicaid payment and financing. I'm going to try to move through this first session pretty quickly so that we can get on to a couple of speakers that we have.

The purpose of this first session is really twofold. First, we want to review the draft Medicaid financing and payment chapter outline for the March report, and then I'm going to give a brief, very high-level overview of Medicaid financing.

First, the chapter outline summary. As you'll recall, the information that we propose to cover in this chapter came out of some discussions that we had this past summer. Earlier this week, I think as you're all aware, we released a MACBasic on the provider payment process. In this chapter we want to continue that discussion by focusing both on how payments are financed and continue to lay the foundation for our understanding of how providers are paid. In the state and federal Medicaid financing piece, we're going to do a brief, a really high-level overview of these subjects this morning. In the provider payment portion, we would propose to cover the different types of payments that go to providers, including direct

service-related payments, capitated payments, and supplemental payments, including both DSH and payments made under the upper payment limit programs.

Let's start with the fundamentals of Medicaid financing, a warm and fuzzy topic indeed. In order to fully understand issues relating to Medicaid payment, it's really important to understand how the program is financed, and by that I mean literally, Where does the money come from that finances the Medicaid program?

This slide is basically reminders for you all. Medicaid is jointly financed by the federal and state governments. The federal contribution to each state's program is largely governed by the Federal Medical Assistance Percentage. States are required to cover certain populations and benefits, and others are at the option of the state. And, again, within certain parameters, states have flexibility to determine the actual payment rates to providers. States spend their money on the program and then submit quarterly reports, known as the CMS-64, to the federal government to obtain the federal matching funds.

As you can see in the pie chart here, for fiscal year 2010, 68 percent of total Medicaid expenditures came from the federal government, and an important note, which I'm sure is a reminder, is that in fiscal year 2010 the federal share was higher than usual due to a temporary increase in the FMAP. Generally, the federal share of Medicaid is closer to about 57 percent.

So federal Medicaid spending is ultimately determined by the amount that states spend. The federal share for most Medicaid service costs is determined by the FMAP, and the FMAP is generally determined annually and provides higher matching rates to states with lower per capita incomes relative to the national average.

The federal share for Medicaid administrative costs does not vary by state and is generally 50

percent. There are some cases where states are able to get a higher administrative matching rate, and that includes things like administration of their MMIS systems as well as to pay for medical professionals, utilization review, and some other things.

So federal is easy. States is a little bit more complicated. As you'll see on the slide here, there are three main ways that states fund their Medicaid programs. Those include general revenue. They include contributions from other governmental entities, commonly referred to as IGTs and CPEs, and they also include health care-related taxes.

I want to emphasize that you often hear the term "state share," and a more appropriate term is actually "non-federal share." The reason I say that is not all of the state share actually comes from the state, as we're going to talk about a little bit more in a second.

VICE CHAIR SUNDWALL: Jim, I hate to interrupt you. I'd just appreciate a little more definition of a CPE.

MR. TEISL: We're actually going to cover each of them in the following slides, so I'm just giving you a preview of what's to come.

I also do want to point out that it's important to remember that the use of all of these are specifically authorized by Title 19. States make individual decisions regarding the extent to which they use these different financing mechanisms, and those decisions are the result of a lot of factors, including state budgets.

Starting with state general revenue, general revenue are general funds that the state collects through income taxes, sales taxes, other general taxes and appropriates to the Medicaid program. This pie chart here is the result of a 2009 survey by the National Association for the State Budget Officers, and it shows that the vast majority of Medicaid funds are from state general revenue.

The one caveat I'd give for this pie chart is some state budget offices weren't able to disaggregate their funding, so that 78 percent may be slightly overstated, but the point remains that the majority of funds come from state general revenues.

COMMISSIONER ROSENBAUM: I'm sorry. Do you mean that the vast majority of what states put -- I don't know how to ask this question. The vast majority of actual dollars that go in are non-federal versus the vast majority of where the states are reporting from? In other words, if you had a few big states where this wasn't true, then 78 percent of all the state dollars wouldn't be general fund dollars?

MR. TEISL: That's true. This pie chart represents the universe of non-federal funds nationwide.

COMMISSIONER ROSENBAUM: Okay.

COMMISSIONER RILEY: I'm a little discomfited by the description of non-federal because I think we have to make clear that even though it may not be a general revenue, it still takes a state action to authorize a provider tax and a state action to authorize an IGT. So it seems to me we ought to be a little careful here, recognizing that disaggregation is important to know. But to somehow make the assertion that it's not a state's money I think is incorrect.

MR. TEISL: That's absolutely true, and the reason we sort of present it this way is we want to explain sort of general revenue and then the other sources of non-federal share, and we're going to get to those in just a second.

The one other note I want to point out here is that, according to the statute, at least 40 percent of the non-federal share has to come from the state, and up to 60 percent can actually come from local governments.

So other non-federal funding sources include intergovernmental transfers and certified public expenditures. Starting with intergovernmental transfers, these are literally -- and they're really quite simple. They're literally a transfer of funds from another unit of government to the Medicaid agency, and then those transferred funds are used by the state for Medicaid expenses. IGTs can come from a local government, a county or a municipality. They can also come from another state government entity. And in both cases that governmental entity may, in fact, be a provider, such as a county hospital that transfers the funding to the state, which is then used to finance Medicaid payments to that provider.

IGTs are commonly used by counties to contribute the non-federal share for certain public providers. A good example here is community mental health centers, and, again, I mention public hospitals also may transfer funding.

In some cases IGTs occur between units of state government. For example, the Department of Mental Health may transfer funds to be used as the non-federal share of mental health services in the Medicaid program.

Certified public expenditures are a little bit different. In this case a governmental provider actually makes an expenditure that's eligible for match under the Medicaid program. That provider certifies that the funds that it spent are public funds and that they support the full cost of that Medicaid service. And based on that certification, the state is able to claim federal matching funds. These are most commonly used for school-based services, though there are states where they're used for other governmental providers, including even hospitals.

I want to just remind everybody that both of these are explicitly authorized in Title 19, and they're actually very commonly used by states.

COMMISSIONER GABOW: I think it's important to note that both of these are then matched, because you made the comment that the IGTs are transferred to pay for Medicaid expenditures.

MR. TEISL: Right.

COMMISSIONER GABOW: But they're also matched.

MR. TEISL: Right. So in the case of an IGT, that non-federal share is transferred to the state. Then when it gets spent, that expenditure is eligible to draw down federal matching funds. In the case of a CPE, the provider spends the entire amount up front, and then the state can use that certification to draw down the federal funds.

CHAIR ROWLAND: And hasn't there been some movement to try to move from IGTs to CPEs?

MR. TEISL: In certain cases that has been the case, and I think the reason is to try to ensure that the total amount being spent and matched exactly matches the cost of care for the public provider, the governmental provider.

COMMISSIONER GABOW: I think the other reason why CPEs have been favored over IGTs is because if the IGT – you may not get it all back in the Medicaid program in an IGT. I think that was what was happening in some states, which created the movement to CPEs. I don't know what you think about it.

MR. TEISL: I think that is also true, yes.

CHAIR ROWLAND: And California is a state that uses a lot of CPEs?

MR. TEISL: Yes, they actually use them for their hospitals as well, for their governmental hospitals.

CHAIR ROWLAND: And other things.

COMMISSIONER CHAMBERS: California's 1115 waiver they did, a piece of it was for early expansion of Medicaid as a bridge to 2014, and so it has been used, county medically indigent programs where, you know, in our county as an example, 80 percent of indigent care folks will be on Medicaid in 2014. And so they're county expenditures that are total county funds formerly for the indigent program are eligible for CPEs because the waiver allows for early expansion of Medicaid for 2014.

CHAIR ROWLAND: This is one of my areas where I think an example when we are working on chapters of actual utilization of these would be helpful for people to understand how they actually work.

MR. TEISL: Absolutely.

Many states use health care-related taxes to finance their Medicaid payments, and again, as authorized by statute. Health care-related taxes are taxes for which at least 85 percent of the burden falls on health care providers. These are extremely common, and according to a recent survey, 46 states and the District of Columbia have at least one of these provider tax programs in place.

Nineteen separate provider classes are eligible for provider taxes. By far the most common of these are on nursing facilities, hospitals, and ICFs/MR institutional providers.

One thing I want to mention is tax revenue is required to be reported on the CMS-64, and in fiscal year 2010, tax revenue reported was $13.5 billion. The rates and other information regarding the taxes aren't routinely collected and sometime are a little trickier to find. We'll talk about that more in a second.

Health care-related taxes are subject to very specific federal requirements. This could be its own full-day discussion, so in the interest of time, we're going to try to keep it pretty brief and basic.

The taxes have to be broad based and uniform. What that means is all providers in a class -- for

example, all nursing facilities -- must be taxed, and all nursing facilities must be taxed at the same rate. Waivers can be granted, but the state has to demonstrate that the tax revenues are generally redistributed among providers. That is, there have to be winners and losers in these tax programs.

Providers can't be held harmless unless the tax falls within the safe harbor threshold, and this is an important point. The safe harbor is currently 6 percent of net patient revenue, and that effectively acts as a ceiling on provider taxes for states. So provider taxes are, in essence, held to 6 percent of net patient revenue. But as I mentioned before, since the rates aren't reported, it's hard to say how many are at or near 6 percent or lower.

COMMISSIONER ROSENBAUM: A question. So how does that get enforced then? Is it done on an audit?

MR. TEISL: You know, it depends on the tax. If the state applies for a waiver, for example, they submit quite a bit of information regarding the tax, and the rate can be ascertained from that information. There are other cases where the information is unavailable.

I want to turn at this point to an issue that's not technically financing but often gets so intertwined with financing that inevitably financing discussions lead to discussions of supplemental payments. This is also going to help lead us into our next session. One of our speakers will talk more about it.

Supplemental payments are typically lump-sum payments that are made in addition to the standard Medicaid payment for services. These payments, again, are in lump sums and not necessarily associated with any particular service or beneficiary. These include DSH payments, disproportionate share payments to hospitals, as well as payments under the upper payment limit. And as you'll remember from last year, the upper payment limit is a reasonable estimate of what Medicare would have paid in the aggregate within a

class of providers. States will make supplemental payments under that limit in these lump sums.

Provider taxes or health care-related taxes and intergovernmental transfers are often used to finance these supplemental payments, which is why these issues often get so intertwined. This is another area where information historically has been pretty limited. On a couple of occasions, the GAO has issued reports saying more information is needed about the amounts of these payments and who they're going to and how they're calculated, et cetera. They are reported on the CMS-64, but they have to be reported by states by provider type in the aggregate. Fiscal year 2010 was the first time that they were reported. It looks like there was some underreporting, being the first year that it had to be done. States reported $15 billion in UPL payments and another $17.5 billion in DSH payments. Again, though, that was just reported in the aggregate, not at the provider-specific level, for example.

VICE CHAIR SUNDWALL: Jim, could you just say, is this an area of concern or has this been an area of enforcement, as Sara was saying, of misuse of these transfers? If you're using intergovernmental transfers to finance your supplemental payment, it seems on the surface kind of clever accounting.

MR. TEISL: Yeah, I mean, some time ago -- and people can probably give you a better range of dates, but let's say in the 1990s -- there was a lot of activity in this area, and CMS grew concerned about the fact that big supplemental payments were being made and transferred.

To the best of my knowledge, CMS has been able to largely wipe those kinds of things out through their regulatory authority.

IGTs as a financing mechanism for supplemental payments isn't necessarily problematic and, as I said before, is actually authorized by the statute. In terms of the sort of gaming that you're referring to, I don't see much example of it today, though I know it was a big issue historically.

COMMISSIONER ROSENBAUM: I must say I am probably in the minority on this, but I think to understand a lot of this, it's really important to understand the program in '65. And because the program was an overlay on the states' indigent care systems as they existed in 1965, I actually have no problem at all with the notion that your state expenditures might be essentially spread across your public commitments to health care for the poor, some of which would be then qualified for federal contribution.

I think that the past 50 years have been an effort to try and become clearer about which parts of a state's indigent health care financing system will qualify for the federal contribution, but I think that a great disservice has been done to states actually in suggesting that the mechanisms that they use to finance health care for the poor, which may vary from state to state depending on the state's traditions, are somehow suspect unless it's a cashed out system. I think great damage is done to public health and safety net programs if we take too narrow a view. And I think that when we explain this in our Basics, we should try, for people who don't understand the origins of the program, to make people understand what Medicaid's arrival was like in 1965. It was understood that states would not simply put their expenditures on the table as cash, that it was building on the indigent care financing system that existed and that varied by state, and that's why the term "expenditure" was not defined in the original statute. It was left undefined to be able to accommodate the conditions that the states found themselves in in '65; otherwise, the law would have been impossible.

MR. TEISL: I'll go through these very quickly, but we submit a few policy questions for your consideration in this area. You can see them, but they have to do with the fact of do policymakers have enough accurate and reliable information and do the Medicaid financing methods affect how payments are made and the amount of those payments, and so we submit them to you to consider and also to help sort of

give us guidance on where you want us to go in this area.

CHAIR ROWLAND: One or two questions, and then really move on to the next part of our discussion, which kind of piggybacks on this part.

MR. TEISL: Right.

COMMISSIONER HOYT: If you can collect this, I'd be interested to see how the dollars vary state by state, the current tally in the last year or two, total dollars, dollars per recipient.

MR. TEISL: Which dollars?

COMMISSIONER HOYT: The UPL, the supplemental payments that you're talking about. My understanding is it's all over the map.

COMMISSIONER GABOW: To your second question up there, I think that the issue of UPL in managed care has to be put forth because I think at the time of UPL no one was anticipating managed care. Now that we're moving everyone into managed care, that affects the UPL payment. It actually is a barrier for some states to move to what might be a more coordinated and efficient model. So I think elucidating --

CHAIR ROWLAND: That's a great way to key up our next panel.

MR. TEISL: Totally unplanned.

CHAIR ROWLAND: Well, Jim, why don't we move on to our next panel?

Burt.

COMMISSIONER EDELSTEIN: Diane, while they are changing over, on the policy questions, I think it's important to connect payment and access. So on the second question, how do Medicaid financing methods affect how providers and managed care plans are paid and payment amounts, I think we

should extend that to, and what is the effect of financing methods on provider participation.

CHAIR ROWLAND: Good point.

Okay. Well, we're going to welcome Jim back to the table, but we'd like to also welcome Billy Millwee, the Medicaid and CHIP Director for the State of Texas, and Robert Damler, the Principal and Consulting Actuary for Milliman. Good to see you both again, and thank you for coming to join us. Jim, do you want to tee us up?

PAYMENT AND FINANCING ISSUES IN MEDICAID MANAGED CARE EXPANSION

* MR. TEISL: Yes. Thanks very much. So in this part of the discussion, we're going to talk about some of the payment and financing issues related to Medicaid managed care expansion, including one that was just raised, and that is the impact of UPL supplemental payments on State decisions to expand their managed care programs, as well as the importance of risk adjustment in managed care rate setting.

And before I hand it over to the speakers, I again submit just some policy questions for consideration. Do fee-for-service Medicaid payments, including supplemental payments, affect State decisions regarding managed care, as well is our managed care payment methodologies sufficiently robust and adjusted to pay efficient plans for the higher cost and higher need populations, and do risk adjustment methodologies, particularly for those populations, accurately predict risk.

We are planning to do a little bit of work in this area and suggest that we would like to do a description of the requirements and approaches for calculating upper payment limits as well as a description of some UPL payment programs used by States. We are working on some profiles of individual payment methods and trying to examine more closely this UPL-managed care interaction. We also intend to try to

describe risk adjustment methodologies used by States, especially for these populations.

And with that, I will hand it over to Billy Millwee.

* MR. MILLWEE: Good morning. It's a pleasure to be with you today. My name is Billy Millwee, as Diane said. I serve as the Texas Medicaid and CHIP Director. It's a pleasure to be with you today.

First of all, let me thank you for your service. Medicaid is very much dependent on advisory committees at the local, State, and national level and we become better for the work that you do, so thank you very much.

I want to talk to you today briefly about the Texas STAR+PLUS program. It's a managed care program for people with disabilities, aged and disabled, how the UPL program impacts or inhibits our ability to move more people into managed care and expand managed care, and then our proposed solution through a Medicaid 1115 demonstration waiver.

In Texas, we have the STAR+PLUS model. It's the classic case where about 25 percent of the people on Medicaid account for 50 percent of our costs through the aged, blind, and disabled. In 1998, we implemented a pilot, and here is what the pilot was about and what it does. It integrates acute and long-term care services for this population, provides them in a capitated delivery model.

In Houston, we implemented the model in 1998 and we had about 58,000 people enrolled in that program. About half of them are duals. Today, we have a quarter-million people enrolled in the STAR+PLUS program. We intend to expand that program effective in March of 2012 and we will have about 400,000 people in the program. Again, about half of the number will be duals.

The program works. We've had independent evaluations that show that the program reduces cost.

It keeps people in the community, out of nursing homes, increases access and quality of care. And at the same time, the members are happy with it. Our survey results through our CAHPS surveys consistently reveal that people like the model.

Upper payment limit -- Jim talked a little bit about upper payment limit. It's basically a supplemental payment program for hospitals that allows hospitals to receive additional reimbursement and it's, at a very simplistic level, it's the difference between what Medicaid pays and what Medicare would have paid. In some instances, a hospital can receive the difference between what Medicaid paid and actual charges.

In Texas, the program is large. We have about $2.8 billion a year that go out in UPL payments to hospitals.

UPL and managed care. Here is the disincentive, is that CMS has interpreted the Federal UPL rules to mean that you cannot have UPL in managed care. So your managed care capitated days cannot be included in the calculation of the UPL payment. So the States are faced with some perverse disincentives, actually. Do you continue with a less effective model to preserve UPL or do you move in managed care and then have a negative financial impact on your underlying health care financial structure.

That affected us in 2005. We took the Harris County model, the model STAR+PLUS pilot in Houston, and wanted to expand it to several different counties in the State. We did so, but in doing so, expanding STAR+PLUS, we carved out inpatient services. Now, is that a rational choice you would make normally if you were designing a health care system? I don't think so. It's the highest cost component of health care and probably the one that should be managed more directly and aggressively. But because of the loss of UPL and the impact it would have on our local communities, we had to do that, and we have

operated that way ever since.

But we have an alternative that we're working on now and that is in the form of our 1115 waiver that we're pursuing with CMS, and hopefully will be signed any day now, and here's what it is. The waiver redirects UPL into what we believe is a more transparent and effective model, and it does this -- the waiver has three primary components. Besides expanding managed care, it creates regional health partnerships. These regional health partnerships, the hospital districts serve basically as the anchor. Where we don't have a hospital district, we're building consortiums of counties and university systems. These groups serve as the regional health partnership to develop regional health plans. Through those regional health plans, we administer an uncompensated care payment program and a delivery system reform incentive payment program. Those two funding pools are funded by the managed care savings and the diversion of those UPL dollars. The uncompensated care payments are limited to cost, not charges, and the delivery system reform incentive payments are based on accountable measurable projects that are going to reform not just Medicaid, but the entire underlying delivery system, because everybody is going to benefit from those changes.

Very much locally driven. We have some requirements. For instance, diabetes, we are going to require that every regional health partnership address the treatment of diabetes because that's an issue in our State. But many of these projects are going to be based on what the local community really needs, and when we look at them, of course, we're looking at how we might benefit -- the Medicaid population might benefit from those.

I think it's a step forward because, one, we're getting more transparency about what those supplemental payments are going to do, what they're going to achieve, and it brings the delivery system in

alignment. We're also aligning our managed care plans along more of a quality basis so they'll be in key with these regional health partnerships.

It's a win for the State. It's a win for the Federal Government. It's going to serve to help limit the Federal Government's liability in UPL and also drives some very necessary reforms that we need in our health care system.

If we don't get the waiver, I guess I could roll out the parade of horribles here, but basically, we will continue the carve-out model for STAR+PLUS. We'll have to because we cannot pull $2.8 billion out of our system that we have grown accustomed to having within the hospital system. We will not expand our STAR program, the State of Texas Access Reform model. STAR is for women and children. The hospitals will take a payment reduction equal to the amount of savings the State would have achieved if we would have pursued these objectives. A payment reduction to hospitals actually translates into an increase in UPL, because remember, it's the difference between the two.

And we'll lose a great opportunity to improve our system, improve the accountability, and prepare us for the number of lives that will be coming in the Medicaid program. In Texas, we will have in 2014 about 1.2 million new lives in Medicaid, so we really need to start preparing for that now and we'll lose that opportunity.

So that's the end of my formal presentation. If you have any questions, I'd be glad to answer for you.

CHAIR ROWLAND: Do you want to take a few questions for Billy now and then go on to the risk adjustment discussion?

VICE CHAIR SUNDWALL: I'd just like to make a comment. Thank you for your presentation.

I have an appreciation for Texas only because the State Health Officer there is a good friend of mine, David Lakey, and I understand the difference in Utah and Texas. They've got 29 million people. We've got three. Your Medicaid population exceeds the population of our State.

But anyway, you said one thing that I think it just stuck with me, when you said the $2.8 billion our hospitals have been accustomed to getting. There's nothing customary about what we're doing now. Everything is going to be different, and if I understood your waiver, you're able to save a Federal contribution but have more flexibility in how you do the services if you get this latitude. Can you just tell me again how the Feds would pay less but they would still continue the level of funding you're getting?

MR. MILLWEE: The Feds pay less on two levels. One, the savings from managed care, and if you looked at the trend in UPL, it's got a straight up trajectory. So the Federal savings also comes from the reduced UPL liability because we're managing those lives. So you get the immediate savings from managed care, acute care, the savings that we get from the STAR+PLUS program, and then you're putting some downward pressure on the UPL trend.

CHAIR ROWLAND: Okay. Richard and Sara.

COMMISSIONER CHAMBERS: So as I understood you to say, you want to do this under a 1115 that's under consideration?

MR. MILLWEE: Yes, sir. We've submitted the 1115 and we're working through some final details, I hope, and we'll arrive at approval soon.

COMMISSIONER CHAMBERS: Can you share with us what CMS has said? It makes sense, what you say is the goals and the outcomes, and I'm just curious what they're saying as to what are the barriers for implementing something like that.

MR. MILLWEE: CMS has been very helpful in this waiver. In fact, we have a letter of agreement that we crafted with CMS in late September or early October that indicates we've reached agreement in principle. We're working through a few outstanding issues between CMS and, I believe, the Office of Management and Budget around some standard special conditions. So I'm hopeful we'll have approval by Thanksgiving.

CHAIR ROWLAND: Okay. Sara, Mark, and Andy.

COMMISSIONER ROSENBAUM: I am particularly interested in the regional health partnerships. Are those totally within the managed care networks or are there relationships being drawn between managed care and public health on some of these broader population improvement goals?

MR. MILLWEE: Yes and no. What drives the regional health partnerships are the funding entities, if you will, for the IGT that funds the current UPL program. So these groups of public hospitals then form regional health partnerships with other hospitals within that alliance or other outpatient groups or whoever else wishes to participate.

The HMOs are involved because their focus is a little bit more narrow on Medicaid, but what we have done is -- and we have five percent of the HMO premium at risk based on achieving some quality performance standards. What we want to do is align the HMOs with the direction of the regional health partnerships to achieve a common objective, but the larger vision of the regional health partnerships is underlying system improvement, and –

COMMISSIONER ROSENBAUM: So essentially, it's a partnership between the managed care entities as entities and the hospitals that will work alongside them around specific quality -- so I assume they will be in the networks, as well, in many places, but mostly, they will be doing focused health improvement

activities as sort of a related activity to the managed care enrollment proper.

MR. MILLWEE: That's right. A lot of the initiatives around addressing potentially preventable events related to admissions, readmissions, complications, emergency department use, and ancillary services. So you can't really get there without having an integrated approach to it. So it does help -- it creates a financial incentive for people to work better together.

COMMISSIONER HOYT: Does Texas have premium taxes or provider taxes, assessments, in place now, and if so, are they going to change under the waiver?

MR. MILLWEE: We only have -- there is a broad-based premium tax on all HMOs and there is an ICF/MR tax, and that's the only tax we really have. There's no other assessments, and those aren't affected by the waiver.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: So taking your example and sort of bringing it back into our role to think about how these particular examples may translate into national policy, I want to ask, I guess, sort of two related questions.

One is what is a Federal policy change that would have allowed you to meet your goals in a similar way? For example, is it as simple as, well, if managed care were a category where UPL was available -- I'm not exactly sure how mechanically that works, but is that a simple policy change that would have allowed you to do what you are doing? And what are the pros and cons of a waiver approach in developing your system? I mean, obviously, there's a whole lot of hurdles to jump over and things like that in going through a waiver and the risk that it won't be approved. But is there a simple solution in a national policy change around UPL or is it more complicated than that from the Texas perspective?

MR. MILLWEE: Well, through the years, I've learned there's nothing simple in Medicaid, but --

[Laughter.]

MR. MILLWEE: I think that could probably be addressed by CMS, but I think it could be as simple as a rule change that prohibits today -- it's an interpretation of a rule that prohibits multiple payments in a managed care setting. So I think that would be a question for CMS. Could you reinterpret that rule or reissue the rule so that UPL could continue in managed care at -- yes, so that you did not have this disincentive. That's been our interpretation of that.

Going the waiver route, it is intensive. It's an intensive process. We started working on this waiver in March and I hope we will have it concluded soon. I can just offer nothing but praises for the work that Cindy Mann and CMS have -- the assistance they've been giving us and the amount of staff time they've devoted to this, but it is an intensive process, a very intensive process.

CHAIR ROWLAND: Burt.

COMMISSIONER EDELSTEIN: I believe you noted that the program currently serves women and children primarily, is that right?

MR. MILLWEE: Yes. Twenty-five percent of our population are aged, blind, or disabled. The remainder, or about 75 percent, are women and children.

COMMISSIONER EDELSTEIN: Okay. So my question is if, and how, if it does, EPSDT is impacted at all, since there is -- the examples of major cost savings that you listed typically don't apply to the majority of kids in EPSDT.

MR. MILLWEE: Well, we're not doing anything in the waiver that would limit or restrict EPSDT, so I would have to say to no. The waiver affects them only by driving delivery system improvements and

long-term will improve the care that they receive.

COMMISSIONER EDELSTEIN: And how does the upper payment limit calculation work for those few services that don't have a Medicare analog, like dental services?

MR. MILLWEE: Well, dental -- they're not delivered -- we are working on, believe it or not, a dental UPL program, and that's services provided by a dentist through a public institution. So there would be an equivalent amount that would be assigned. Generally in dental, we use the ADA rates that are regionally based. But for those services that aren't Medicare equivalent, sometimes the charge, the charge cap comes into play.

CHAIR ROWLAND: Okay. Let's turn to Rob and then we'll come back for general questions.

* MR. DAMLER: Good morning to everyone and thank you for this opportunity to speak with you regarding risk adjustment. I'm going to go ahead and walk through this presentation here, which I believe all of you also have in front of you.

Risk adjustment may seem like a very daunting subject, but risk adjustment really refers to the application of information to vary a capitation rate or payment to reflect the underlying morbidity of a population.

There are many ways to risk adjust. Risk adjustment has been used in managed care programs or in the Medicare program, health insurance programs, commercially insured programs, for many years, really, since the programs.

There is basic risk adjustment, we've illustrated here. In the Medicaid program, basic risk adjustment is age and gender, geographic region, eligibility categories, pregnant women, low-income families, disabled populations. All of these are ways to take information -- data and information that's

specific to a particular population and vary a payment rate to a health plan to reflect the risks of those individuals enrolled.

Another risk adjustment method is case rates. I've illustrated here three different ones, a maternity delivery payment, a newborn delivery payment, a neonate ICU risk pool payment. Again, different methods of applying capitation payments or risk transfers of payment between the State Medicaid agencies and the contracted health plans.

The more complicated methodologies are diagnosis-based, pharmacy-based, or more recently, within the last three to five years, a combination of diagnosis and pharmacy information.

Risk adjustment methods are used in both direct and indirect methods for capitation rate setting. The indirect methods I've identified here first. Selection factors. As many of you know, not everyone is always mandatorily enrolled into health plans. There are always individuals that are excluded from enrollment into health plans. And so, in general, higher morbidity individuals are not enrolled into health plans. They may be on a waiver. They may be institutionalized. It would be retroactive eligibility periods. There are all of these different exclusions from enrollment into a managed care plan. So selection factors adjust historical data to reflect the changes in enrollment in either a voluntary or mandatory population.

We also need to have population normalization. Again, we may have, as in the State of Texas currently has a PCCM program and a risk-based managed care program operating side by side. Massachusetts does the same thing. South Carolina does the same thing. Well, when you have two different programs operating side by side in this situation, like a medical home network program and a risk-based managed care program, where individuals can choose where they enroll, selection will occur. A

risk-based program needs to reflect that morbidity selection. Oftentimes, higher-risk individuals will choose to stay in fee-for-service or in the medical home network-type model rather than enrolling in an MCO. Again, this is an indirect method of providing risk adjustment.

Population expansions. We have an expansion in 2014. How will risk adjustment be utilized to take data and information from today and adjust for these new populations, the populations that are going to be enrolling in 2014 or before, individuals that are newly insured, elderly, individuals that have pent-up demand. All of these things become a risk adjustment issue.

The most direct method of risk adjustment is in capitation payments. Capitation payments are either increased or decreased on a periodic basis to reflect a risk for the population enrolled. So we may have, let's say, a disabled population grouping. The disabled population may be spread across three different health plans. Risk adjustment reflects the relative morbidity of the populations enrolled with each of those three individual health plans. Selection does occur. Higher-risk individuals may choose one health plan over another because of the provider network, the hospitals, the physicians, the geographic region, et cetera. All of those things can come into play. So a direct method of risk adjustment is modifying the capitation rates and increasing or decreasing either on, like I said here, on a periodic basis.

In a direct methodology, risk adjustment is implemented on a budget neutral basis in relation to the State Medicaid agency when applied to the capitation rates. Therefore, risk adjustment will target a 1.0 composite reimbursement rate to all of the health plans. So, therefore, if the average per member, per month cap rate may be $500, the State wants to continue to pay $500 across all three of those health plans, on average. However, one health plan may be receiving more than $500. Other health plans are receiving less than $500. But again, they want to normalize it out to have a 1.0 across the health plans.

Again, budget neutral. However, some plans will receive more and others will receive less.

Risk adjustment frequency and methodologies do vary. There's a concurrent methodology or prospective methodology. Concurrent just basically says, use diagnosis or pharmacy information from this year to predict this year's expenditures. Prospective, use data and information from this year to predict next year's expenditures. Those are two different methodologies and frequency really varies from State to State. We have some States that do it monthly, quarterly, semi-annual, or annual, so really have the full gamut of frequency of applying risk adjustment and remeasuring the risk adjustment.

Risk adjustment population considerations. The TANF populations, which include the low-income, the pregnant women, the CHIP populations, have a much higher turnover, and age and gender is generally a good overall predictor of health care risks. You have a much lower percentage of individuals will be scored. A lot of the individuals do not have pharmaceutical or go and see the doctor for a chronic or acute care condition. They may go see a doctor for having a cold or the flu that year, but that is not a predictor of next year's costs.

Newborn and maternity are a high portion of costs. Again, you can predict those costs in a different way and pay those a different way.

The disabled population, much lower population turnover, much greater prevalence of chronic conditions, and a significant portion will receive a risk adjustment risk score. So this is a population where age and gender is not a good predictor, but diagnosis and pharmacy is, and there is a significant variation across those that are disabled in the SSI disabled populations.

Another issue is how to handle the unscored recipients, individuals where you don't have historical data and information to draw upon. How do you pay on those? And that's just an additional issue that

the actuary needs to take into consideration.

There are many variables that come into play in risk scores -- diagnosis codes, what provider types, how many diagnosis codes per claim do you accept. Oftentimes, diagnosis codes from laboratory claims may be excluded. Why? Because a physician may use a laboratory claim as a rule-out diagnosis. Let's test to see if this patient has diabetes. Well, just because that diabetes code shows up once on a laboratory claim does not indicate that the patient has diabetes.

So there are different types of providers that you can exclude. Prescription drugs, the same issue. All classes of drugs or restricted classes of drugs? Again, there are some classes of drugs that are very high frequency that aren't necessarily an indicator of someone having a chronic condition.

How do you combine diagnosis codes with pharmacy data? Do you continue to retain the age and gender variable? That does have a little predictive value, even in the disableds, not as much as diagnosis and pharmacy.

You can use national weighting versus State-specific weighting. There are national rates available for risk adjustment. How much higher does a patient with diabetes cost in relation to the average disabled? So you could use a national weight or you can get into a State-specific weight. State-specified weight takes a little bit more data and information, more work, effort is involved. However, you can develop State-specific weights.

Again, understanding the update frequency, monthly, quarterly, et cetera, geographic delineations, and corridors. Do you allow the risk scores to vary greatly from a 1.0? So do you allow some health plans to have a 15 percent higher risk score and others to have a 15 percent lower risk score, or do you kind of create a corridor so there's not great variations in the payments between the different health plans?

Implementation issues are very important and it takes a lot of time and energy and discussion between the actuaries and the policy and decision makers at the States.

Data completeness and accuracy. Data completeness is going to be a very big issue if you're transitioning -- if all of your members are in a managed care program, you need to make sure that the encounter data -- encounter data systems have historically had difficulties in getting good and complete data, and so what the actuary needs to do is work with the State in building a strong encounter data system.

There needs to be an understanding between the capitation rate setting process and the risk adjustment process. Everyone needs to understand those issues.

How can a rate of increase or decrease in a health plan's risk score? I have observed situations where a health plan's risk score increases by ten percent from year one to year two, even though the number of people that they have enrolled really didn't change that much. Did they really have a ten percent sicker population, or was it just better coding, better information? So you have to look those types of increases and decreases.

What are the differences between reporting capabilities of different health plans? Some health plans are large national health plans that have very sophisticated reporting systems in working with the physicians and doctors and hospitals. Others are smaller and local or regional health plans that may not be as sophisticated in reporting all the diagnosis codes.

Health plan provider reporting incentives versus care management and outreach. If a health plan encourages the physician to see all their diabetic patients, is that good care management or is that just making sure they get diagnosis codes for all their diabetes patients to get them scored and get a higher risk score? So we need to take that into consideration.

The other important consideration is predictability of rates for health plans. Remember, the state is going to pay $500 on average in my example that I used earlier, $500 on average per person. Well, until the risk scores are published, a health plan really doesn't know are they going to receive $500 or not. Last year the risk score was 1.02, let's say as an example, so they received $510. Well, maybe because everybody else's risk scores were improved or diagnosis reporting made better, now their 1.02 is a 0.95, and so they're going to see a significant drop in their revenue. So predictability of rates is very important for the health plans.

This last slide, I received a copy of this from John Kaelin, who works with United Healthcare. He presented this at a Medicaid managed care conference back in early October. On comment that he did make about this slide is it may or may not be fully up to date. This is just data and information they compile over time, so this is just the representation. Actual state-by-state information may vary if you go in and look at this in today's marketplace.

As you can see, there are various risk adjustment models being used, the most prevalent being CDPS or CDPS+Rx. That was developed by researchers at University of California, San Diego. There are a few others that are also being used, but that one is the most prevalent.

That's the end of my comments. Any questions?

CHAIR ROWLAND: Questions?

COMMISSIONER CHAMBERS: Not really a question, but I just really appreciated your presentation, both of you, but particularly on the risk score. As being a health plan that operates in a unique situation because we're the single health plan in the county so we have the ultimate risk adjustment with the state, we have everybody so it's a really easy risk adjustment. But our downstream provider

networks for years is we did not risk adjust payments, and so we used the 1.0 score. And the plans were always sort of like the children in Lake Wobegon; everybody was above average. They all had the sickest members, of course, and said, "You're not paying me appropriately." So we switched to using CDPS, probably about six years ago, and it was an amazing transformation, particularly with the principle of the money following the person, making sure the sickest members were -- the delivery networks were getting appropriate payment. And it really did in some ways transform the system of more accurately getting encounter data suddenly when there's payments attached to proper coding and reporting. But it's the right way to do it, and I certainly am glad to see so many states moving towards risk adjustment because it really is the right way to go.

COMMISSIONER GABOW: In the risk adjustment, is there any variable for sort of social determinants of health -- owning a house or renting, being homeless, living in certain neighborhoods, being non-English speaking, things that we know clearly influence outcomes? I've never seen them, I don't think, in a risk adjustment.

MR. DAMLER: With regard to other variables besides diagnosis and pharmacy, in today's environment of the risk adjustment tools that are being utilized, they do not include those types of variables. I have been involved in a lot of discussions, how to introduce those variables. I work with one health plan that subcapitates down to providers, and this one provider group really wants the non-English-speaking variable put into play because they believe that really has influenced their health care delivery system cost. It increases their cost, the time with the patient, all of those types of variables.

So I think as the diagnosis and pharmacy methodologies have really been ingrained into the system, as more people become enrolled into these programs, we will need to start looking at other variables, just

like we have geographic -- you know, we've moved from an age, gender, geographic region, eligibility category variable, we moved to diagnosis, we moved to pharmacy data. So we're adding more and more variables. So I think the research will follow and introduce these types of concepts as well.

COMMISSIONER GABOW: And do you have any thoughts so far in your work about which of these variables will turn out to be important? Certainly language because they have a real cost. You have to pay for a translator. But what about others?

MR. DAMLER: Right. I do think that the income variable needs to be considered as well because the access to care, access to transportation, relationship to where the providers are, I think all those come into play with regard to income and where you're residing. So I do think income will come into play, and I think the language may come into play. But, again, if you have a good provider network that can meet the language needs, then that may soften that variable as well. So there are definitely other issues to try to take into consideration.

COMMISSIONER COHEN: If I understand it, this is a related question, but it's possible I do not. How many states look at SSI-eligible individuals differently, in a different sort of category of risk adjustment than others? In other words, is that common or not common? And is SSI used as like a proxy for other things besides -- you know, obviously, if you're basing your risk adjustment on diagnosis, does SSI give you more information, SSI status, whether in it or not?

MR. DAMLER: Right. So one of the basic variables that I've introduced as risk adjustment was eligibility category. I do not know of any state that does not at least start with stratifying the populations between low-income family -- and I used the term "disabled" because not all states use SSI, but the SSI/disabled type populations. That is the initial stratification, and then they work with setting the

capitation rate for just those SSI/disabled populations, and then work from there. And so they're a separate group from the low-income family, pregnant women, CHIP populations.

Does that answer your question?

COMMISSIONER COHEN: That's typical [off microphone].

MR. DAMLER: As far as I know it is always done, but I --

CHAIR ROWLAND: Bill, do you want to comment on how you do it in Texas?

MR. MILLWEE: We use CDPS, but we also, as Rob was pointing out, use the eligibility categories. But we do a full risk adjustment based on the tools that -- CDPS and Med-Rx.

COMMISSIONER CHAMBERS: Denise, did you have something along these same lines? Because I wanted to go back to supplemental payments, but not to jump around if you were going to talk about capitation of risk, risk adjustment.

CHAIR ROWLAND: Okay, so let's go to Denise then.

COMMISSIONER HENNING: Well, as you were talking, I was thinking basically this whole risk adjustment thing is a way to pay people more because they're dealing with sicker people. And what I don't hear in any of this is how you incentivize people to prevent people from becoming sick in the first place.

As a provider, I spent a lot of time talking to my patients about nutrition, and I do a lot of testing for diabetes and high cholesterol, and I'm a nurse midwife, okay, so this is not something that's traditionally expected of me. But I do it to try to identify these people that are heading in that direction and to stop it before it happens. But I'm actually penalized because I don't see as many patients that way, and my health center pays me to see patients, numbers. That's how they get paid.

So there's a perversity to the health care system that if you spend more time with patients and you

actually try to prevent a disease, you don't get paid. So I don't know how we fix that, but it seems to me that, you know, something needs to be in there to -- the pay-for-performance kind of issues to help, I guess, incentivize the right things in the health care system.

MR. DAMLER: With regard to your statement, risk adjustment is a way to either pay more or less against the average population to reflect the morbidity of those who are enrolled with that health plan. But you are absolutely correct with regard to it is a disincentive to have fewer diabetic patients because you receive more money with higher diabetic patients. It is a disincentive to have fewer patients with controlled asthma, so to speak, because -- well, although controlled asthma probably has pharmacy-related, so it may end up being counted. But the situation is -- and I have had discussions of how do you incentivize making people healthier but not disincentivizing them by lowering their payment, although you do want to make savings in the system, too. You don't want to keep paying them $500 if people are becoming healthier. That is the idea of managed care, reducing trend, bending the cost curve as well.

So it is a balancing act, but that type of variable has not fully been implemented into the system, although there are incentives and bonuses in Medicaid managed care that do help pay for appropriate HEDIS-type scores or follow-ups and immunizations and preventive care and things of that nature. So there are bonuses being paid; however, the risk adjustment does create a little bit of a disincentive in some regard.

COMMISSIONER MOORE: You both mentioned that SSI is kind of an entry, a beginning risk that's taken into account, and I assume that some of the other measures that then come into play later on which pick up a specific diagnosis. But is there any other SSI feature or data that's available from Social Security that's ever used -- or actually the state units that do the disability determination, that's ever used in

the risk adjustment process?

MR. DAMLER: I think what we are going to see in the very near future, as the dual eligibles, more variables will come into play, such as dual eligibility will want to stratify the SSI non-dual from the SSI dual eligible. Once we get into that dual-eligible category, we have many more people on waivers; we have people that are institutionalized; we have patients with end-stage renal disease. There are more variables that will come into play to stratify the population.

In general, the SSI population, again, does have some stratifications. Before you start choosing those who will enroll in the Medicaid managed care plans, you start making -- you could be making exclusions. We have all the SSI/disabled. However, those on a home and community-based waiver won't be enrolled. Those who are institutionalized in either a nursing home or ICF/MR facility won't be enrolled. So those are already ways to risk adjust because you're taking those risks out of the base population. So you need to move from this larger set -- every state starts with the larger set of populations and then starts carving it down to who will enroll. And then once you do that, then you have to determine what type of selection factors need to be applied if you have dual systems, like a medical home network system where people stay fee-for-service payment, but enroll in a medical home network versus those who are in a risk-based managed care HMO-type environment.

COMMISSIONER MOORE: Billy, in Texas?

MR. MILLWEE: Well, we do stratify based on -- more on the services and the nature of the eligibility category. So if they're SSI but not a dual, it's one level. A dual, partial dual, whatever the dual category is. And then if the HMO -- if they're also qualified to receive the community-based services, then it's another level of risk and premium.

COMMISSIONER ROSENBAUM: I wanted to follow up on Denise's question. She put her finger on something that I think is worth just focusing a little bit more on. Risk adjustment is to make sure that there's access for the sickest patients, obviously. Performance bonuses are to be sure that people do a better job with the patients they've got. And I just wondered from your vantage point how extensively -- the extent of experience thus far in sort of trying to align the two.

I would assume that each time you try and up the performance bonus pool, you obviously are pulling some money away from what might be money available for risk adjustment, since money is not infinite. And so I don't know if you have any insight as to sort of the challenges of balancing the two.

MR. DAMLER: There are definitely challenges between the risk adjustment process, the overall capitation payment, and -- there are differences between bonuses and withholds. What you are going to start seeing in the Medicaid managed care programs is withholds will become bigger. Historically, withholds have been relatively small, so if you have a $100 capitation rate as the base amount, historically states have withheld a half a percent or 50 cents or $1 -- half a percent to 1 percent.

What we are starting to see movement towards are withholds more in the 2, 3 -- my understanding recently was one state is doing a 5-percent withhold. And so those withholds are becoming larger and larger. Those are a little bit different than the bonuses where it's extra money above the $100. So I think the combination of both of those things is going to start driving the incentive of healthier patients and creating more management of the care that's to be paid.

MR. MILLWEE: Our new contracts have a 5-percent at-risk amount from the premium, and that's significant because many of -- the profit margin risk is about 3 percent, so you're really getting into significant money to influence behavior, with the expectation -- also embedded in the contracts are some

requirements around patient-centered medical homes and encouraging provider incentives to align some of the things you talked about, to remove that perverse incentive not to treat the people who really need it, and also to align with our other discussion on our waiver.

It's actually a quality challenge pool, so it increases the competitive pressure to perform because if an HMO doesn't meet that standard, then part of their 5 percent will be contributed to a competitor's bottom line.

COMMISSIONER CHECKETT: I have questions for both of you. One of the things that we've talked about as a Commission in our past first year of existence has been the challenge of data when it comes to managed care to really have a handle on performance, cost savings, because there's this whole black box of encounter data. And so I'm wondering, Billy, in terms of how that issue has been in Texas and how you've dealt with it, and, Rob, what you've seen nationally. So that's the first question.

Then a second specifically for Billy is anything that you can share on STAR+PLUS outcomes, because it's really one of the first programs and you've been up and running for a long time, just really focused on capitated managed care for a very high cost population. So two questions.

Thank you.

MR. MILLWEE: Sure. We invested a lot in an encounter processing system. We did that because when we implemented managed care in the late 1990s, we had no data. It just went away. The encounter data was not compatible to claims data. We had nothing really to measure performance. So we invested significantly in an encounter data processing system. We're getting good data now, and we're learning as we go, but the data is good enough to use for risk adjustment and for rate setting and for all those things.

Over the years, we have improved that. In fact, that is paying off because now we can use that data to calculate things like potentially preventable admissions, complications, readmissions, and all those kinds of things. We had some struggles early on, but invested in later years, and now we're reaping the rewards for doing that.

Some of the measures in STAR+PLUS, here's what we've seen: a 22-percent reduction in inpatient stays, and keep in mind that has been even with the inpatient carved out. So we've seen just by having the service coordinator, which is really key to the STAR+PLUS program -- it's either a nurse or a social worker -- linking that person up with the services they need and the services are used more appropriately, you see that reduction, a 15-percent reduction in emergency department utilization. And, in fact -- I was surprised by this one -- it's about a 10-percent reduction in the use of community-based services because they're being used more appropriately.

We've also seen another benefit is that you get a service coordinator, whether you're just Medicaid or you're a dual. So we know that there are savings on the Medicare side, and we're anxious in exploring that to see how we might benefit from that.

MR. DAMLER: I think to follow up on that, with regard to the encounter data warehouse, one of the comments Billy made is that they invested in an encounter data warehouse. Where states have really struggled the most with encounter data is when they've tried to collect the encounter data through their MSIS database. That has created reporting difficulties because many of the claims will be rejected because they won't be meeting the requirements of the MSIS data set. States have taken a lot of initiatives to overcome that, but regular monitoring and reporting of the data, looking at this quarterly, quarter after quarter, in general in my experience it takes 12 to 36 months, depending on how many health plans you

have, to get that data and how long they've been operating before you start really monitoring to get them back in full speed of regular reporting and getting all of the data and information on.

So, you know, this is one of the things with the exchange and the expansion, is risk adjustment is supposed to be occurring in 2014 for all these new populations. Again, you start talking about data warehousing and all of these issues, it's a very big issue for the exchanges. It has been a very big issue for the Medicaid program, and each state handles it a little bit differently. Sometimes it is more success -- I have observed more success when they just start fresh with an encounter data system rather than putting it through the MSIS system.

COMMISSIONER CHECKETT: Thank you very much.

COMMISSIONER COHEN: A question for both of you. I think we have talked about and identified a federal financing-related policy around UPL that has sort of distorted some decisionmaking about when it's appropriate to put Medicaid beneficiaries in managed care, et cetera, and I'm just asking for a little on-the-spot brainstorming, but are there other sort of similar federal financing policies? And I'm going to try and caveat that by saying, you know, other than things that the federal rules will not allow a state to cover -- so sort of beyond something like a benefit expansion, but are there other rules that in your view have really sort of distorted decisionmaking around what you think would provide better quality or cost-effective care for Medicaid beneficiaries in your state? And then, Rob, just sort of in your experience with conversations with various states, if you have a thought on that.

MR. MILLWEE: Well, UPL was certainly a big one. I think some others are around managed care requirements. We've been doing managed care for 20 years, and we still have to go through this waiver process to expand or put managed care in place. And some of the requirements around choice of

health plans, some areas you can't have -- the market would not support two health plans, but you have to have two, anyway. And, in fact, I would argue that the current rules require you to have three because if I'm doing my due diligence, I'm going to put an HMO that's not performing on enrollment suspension. If I only have two, then by doing the right thing contractually, I'm out of Federal compliance.

So I think another look at how CMS manages managed care within Medicaid is long overdue given that the rules were put in place, I think, today based on -- it was a new concept in the 1980s or 1990s and maybe a little distrust. Now we know more.

Finally, you know, we talked about state flexibility, so I think anything to give states more flexibility in how they administer the program also plays into the finances. I know that flexibility is kind of lightning rod word. Some people think that means block grants. Well, we're really just talking about flexibility and let us do the things that will keep us budget neutral but that work for our states.

MR. DAMLER: Let me address the question real quickly. One of the financing issues that more states are trying to understand is for the federally qualified health centers and rural health clinics, there's the RAC payments that are made for those who are enrolled in managed care plans, where the state still pays a supplemental payment on the back end. Many states I think would like to put that into the capitation rate. However, my understanding is it's precluded. I don't know if it's federal regulation that precludes it or a CMS rule that precludes it, but more and more states have been asking to be able to put those RAC payments into the capitation payments just so they don't have to worry about making the RAC payments, estimating the amounts, all of those issues. So that is one area, similar to a UPL, that it does state in the actuarial certification you're not supposed to be putting those monies into the rates. But I think states would like the ability to do that, and then that way they wouldn't have to monitor the services and things of

that nature.

CHAIR ROWLAND: Are there any issues around prescription drug payments?

MR. DAMLER: Now that the OBRA 90 rebates apply to the pharmaceutical program, that really has changed the dynamics of prescription drugs at this point in time.

CHAIR ROWLAND: But not Patty's 340B issue.

MR. DAMLER: I don't believe it has addressed the 340B issue. I'm not sure what the question was on that, but...

CHAIR ROWLAND: We just are always looking for ways to save money on drugs.

MR. MILLWEE: We are just carving drugs into managed care, and we're struggling with the 340B issue as well.

COMMISSIONER CHAMBERS: I wasn't going to comment until you talked about the FQHC wrap-around. California is exploring it with the managed care plans, and even when you get past just the administrative burden and the slowness it takes for states to adjust the cap payment, is looking at the -- I think states are trying to grapple with the explosion in many ways of FQHC and look-alikes.

For instance, in my plan 80 percent of the physicians are private physicians; only 20 percent is through clinics, FQHCs and look-alikes. And many consultants have said, "Why don't you shift that to 50/50? You could bring a whole lot more dollars into the county and probably not change quality or delivery or access." But it would certainly change the federal dollars and the state dollars that are coming into the county and the delivery system. And, you know, the state looks at that as, you know, oftentimes perverse incentives as to how you design a delivery system and provide access to vulnerable folks. And so I think they're trying to figure out how to push it to the local level, to work in conjunction with clinics, to

figure out what's the appropriate use in reimbursement and how to handle that. But it's a very tough political question, particularly with the clinics and the National Association and changing any of those rules.

But my question was really going to be about the issue about managed care and supplemental payments again. Just thinking about what you talked about before, because managed care has been separated from UPL and it's based on actuarial soundness, what's the problem with a state using contracting with managed care plans as a way of flowing funds through the plans to those providers where the supplemental payments go? And I'm curious. Are there federal prohibitions or are there other challenges that I'm just not thinking about?

MR. MILLWEE: We tried to go down that road, and the concept would be that you use the intergovernmental transfer to enhance the managed care premium beyond what it would have normally been. The complexity with that is we have about 300 hospitals in our state that participate in UPL, and there's another rule CMS has that we can't direct payment. We can't tell the HMO how much to pay that hospital. So if we get that IGT, the hospital's perspective is it goes into the HMO black box, and how do I know I'm going to get the return on investment that the county judge, who is agreeing to fund that, is held to by the taxpayers?

So without being able to tell the HMO this county, this hospital contributed this much in IGT so you need to enhance their payment by this amount, it just wouldn't work for us. And I think that's because we have more than public hospitals participating.

COMMISSIONER CHAMBERS: Interesting, because that's not the experience I've had in California, but I won't say any more because I don't want to get California in trouble. But there is --

MR. MILLWEE: Well, if you have -- I think California has a fewer number of hospitals in UPL

potentially, so if you have seven or eight public hospitals, I think that could be easily managed without violating any CMS rules. It's just when it becomes so large that you really have got to communicate to the HMO who is contributing. So that may be the difference.

MR. DAMLER: I think many states have started to look towards the hospital bed tax to replace the UPL system and using the hospital bed tax through the managed care program, and it replaces the UPL -- it can replace the UPL system, and it puts enough money into the system to accomplish a similar effect.

COMMISSIONER CARTE: Just to follow up on the issue of encounter data, I was wondering if in Texas you're able to report the pediatric quality measures that states are voluntarily reporting at this time.

MR. MILLWEE: We are -- we can get there. We have not started reporting them yet, so we do have the encounter data to support that.

COMMISSIONER CARTE: But you anticipate you will?

MR. MILLWEE: We're working on that.

CHAIR ROWLAND: I think this has been extremely helpful and will help us shape not only our financing chapter but much of our deliberations going forward.

I did want the Commission members, if they have comments on the financing and payment outline, which is under Tab 5, to either make their comments now or clearly get them in soon. And I wanted to raise one issue for you to consider as you look at that chapter, which is whether we take on financing and the impact of provider payment policies on the financing but don't try and do an exhaustive review of all the ways in which we pay providers. So think about that balance issue you look at. We're trying to slim down and zero in, and maybe that's an area we could think about.

Any other comments?

[No response.]

CHAIR ROWLAND: Well, then thank you very much to Billy and Rob for joining us today and for your helpful comments that will help us with our deliberations, and we look forward to continuing to work with you. Good luck back in the states and in risk adjusting our managed care rates. Thank you.

Now we'll take about a 10-minute break and then reconvene.

[Recess.]

CHAIR ROWLAND: If we could reconvene, please? Okay. Christie, if you want to kick us off, that would be great.

LESSONS LEARNED IN SERVING CERTAIN HIGH-COST HIGH NEED MEDICAID POPULATIONS IN MANAGED CARE

* MS. PETERS: Sure. Thank you, Diane. This next panel is going to be focusing on state lessons learned serving high-cost, high-need Medicaid enrollees.

CHAIR ROWLAND: Which is Tab 7 for the Commission members.

MS. PETERS: I'm sorry, yes. Including individuals with disabilities and dual eligibles. We are pleased to have with us today Darin Gordon who is the Director of TennCare, and Patti Killingsworth who is the Chief of Long-Term Care for TennCare. And they're here to talk about TennCare's experience serving complex populations in managed care.

Before I turn it over to Darin and Patti, though, I'd like to quickly highlight what the Commission has done to date in areas for complex populations and what our plans are for next steps. Let's see here. That's not good. Okay, bear with me.

Our discussion today is going to build upon some completed and ongoing analytic work of the

Commission staff regarding these populations, as well as previous Commission meetings and discussions.

In the MACStats section of our June report, we had a series of national and state level tables on Medicaid and CHIP populations on their spending and enrollment, and also on demographic characteristics, health characteristics, and use of care for children, adults, and seniors.

And some of the things we reported out in that report included that Medicaid eligibility groups differ markedly from each other in their characteristics, service, and spending, and that half of overall Medicaid benefit spending growth from fiscal year '75 to 2008 was attributable to Medicaid enrollees with disabilities, both the non-dual and the dual populations, and individuals with disabilities and enrollees age 65 and older have per-person Medicaid benefit spending that is three to five times larger than that of other enrollees.

Let's see what the next one looks like. Okay, great. At the direction of the Commission, staff are moving forward with our analytic plan for complex high-cost enrollees, focusing on individuals with disabilities for the March report.

This work includes comparing enrollment expenditure data for the disabled eligibility group to other Medicaid eligibility groups and further profiling the individuals with disabilities population, including examining acute care and long-term service and support use and spending among the disabled, again both Medicaid-only populations and dual eligible populations.

We're going to be looking at the presence of mental health and substance abuse conditions among individuals with disabilities. And also participation in home and community-based waivers. This work is incorporated in the chapter outline in your briefing book.

In addition, staff have begun examining the enrollment of individuals with disabilities in Medicaid

managed care programs. And there's a section in our proposed March chapter that looks at state Medicaid programs for individuals with disabilities and starts teeing up some of the issues we are examining and plan to report on post-March.

As you recall, during our September meeting, we discussed opportunities and challenges to better serve high-cost, high-need enrollees and contain costs affiliated with their care with two panels of experts. The first panel focused on Federal, state, and beneficiary perspectives on these populations, and Federal and state programs and initiatives used to provide quality care and contain costs.

The second panel focused on specific models of care, namely Medicaid managed care programs for the aged, blind, and disabled populations, Medicare Advantage special needs programs, or SNPs, and PACE. This panel focused on some of the challenges provider entities encounter operating programs that specifically target certain complex high-cost Medicaid populations.

The purpose of today's discussion is to further the Commission's understanding of state challenges and approaches to serving complex high-cost Medicaid populations and to explore issues specific to enrolling these populations in managed care by focusing on the experiences of Tennessee's Medicaid program known as TennCare.

TennCare has long enrolled all Medicaid populations including the elderly, the disabled, and individuals with mental and behavioral health conditions in managed care. The program has evolved over time in response to a variety of challenges.

TennCare's experience with managing mental and behavioral health services, and managed long-term care, in addition to their experience working with providers in fee-for-service settings for certain carved-out services such as dental, pharmacy, and certain long-term care services, and the impact of these

state decisions on program management and cost and enrollee health outcomes can provide insights into the challenges and potential benefits of moving complex Medicaid populations into managed care.

In addition, TennCare is pursuing integrated Medicare and Medicaid services and financing for dual eligibles and was awarded one of the 15 CMS dual demonstration design contracts. Darin and Patti will discuss TennCare's proposal and plans for dual eligibles as well.

Okay. So the purpose of this panel is to inform ongoing and future Commission work on coordinated care and integrated models of care for high-cost complex Medicaid populations, in particular, individuals with disabilities and dual eligibles.

Staff are looking for Commissioner comments on its ongoing work and plans for the March chapter on individuals with disabilities, as well as guidance on next steps and future work in this area. So now I'm going to turn this over to you. Frank will--okay, there we go.

CHAIR ROWLAND: He'll set you up.

MR. GORDON: Okay. Thank you. Christie did a good job of setting this up. Wait for the presentation.

CHAIR ROWLAND: There we go.

* MR. GORDON: Thank you for having us. Patti is going to help in two ways. One, if my voice goes out on me, but also to add some additional perspectives along the way.

So many of you know about Tennessee, and obviously we've been involved with managed care. Back in 1994, we put all of our population, 100 percent of our population in managed care. And we were the first state to do that. We were the first state, also, to cover all of our populations regardless of income in Medicaid. And obviously, over time, things have evolved in that regard.

We continue to be TennCare, but we continue to evolve. As I tell people, we change things, it seems like, every day within the program from lessons learned, and we'll talk a little bit about that.

Whenever you do managed care, the thought was that we could cover more people by putting them in managed care, but we could also expand the benefits, and there are some--there were some challenges with that and we'll briefly cover that. But it also evolved how we approached managed care altogether as we learn more in the program.

So starting in the very beginning, and you'll see these slides have a common theme. They'll talk a little bit about what was going on at the time period, and then at the bottom you'll see the different service areas that we had, and we'll talk about some of the services that were carved in and carved out at that time period. I won't hit all the different quality measures, but you'll see how that's evolved as well as time has gone on.

But when we first started out, we had 12 plans, some that were HMO, some that were PPOs. We also had, all the plans were at risk, and we had 12 service areas. We started out with physical health services, dental, pharmacy, and some of the routine mental health services carved in. Other services were carved out. Not for any other reason than anything more--it was a big leap to put everything in that we were putting in in 1994.

But also because there were some apprehensions by some parties with regards to some of the specialized mental health services. And again, things began to evolve, but we started out with--there's one consistent thread through all of here, which is our annual survey, satisfaction survey that you'll see on each slide, and thankfully, you'll see, as we go through here, it keeps improving.

Jumping to 2003, obviously a lot happened between 1994 and 2003, but we had some problems with

some of the health plans and that, in some way, explains what happened with some of the carved-in and carved-out services. So we ended up bringing in the specialized services into the managed care framework.

However, it was believed that maybe through a separate BHO that we'd be able to manage those services better for those populations. We ended up pulling out dental during that time span, and that was partially because we thought that that wasn't the core competency for the plans that we had in the marketplace at that time. We thought we could do better with dental, and so we pulled that out.

Pharmacy actually started coming out for different reasons and it came out in phases. It first came out for the dual eligibles, and really the primary reason being is cost growth. The health plans were having a hard time controlling the pharmacy benefit for the dual eligibles and we were seeing growth rates anywhere from 20 to 30 percent year over year for pharmacy.

So definitely that was a challenge for them, and so it was more or less done in order to have some stability for the health plans. And long-term care continued to remain outside of the services that the health plans provided.

We also, as you noticed, the number of health plans went down. We were down to nine health plans by 2003. Some of the plans were being brought into, and it happened over time, but we brought them into an ASO arrangement. Basically, they paid the claims. We ended up--or we paid the claims. They adjudicated them for us and they continue to do the outreach activities and other care coordination activities that they had been doing.

And part of the reason we had done that is we started seeing some of the health plans struggle in a pretty mighty way and there was concern that the whole program could come unwound when we started seeing some of those health plans fail. This was kind of--think of as a pause. Let's find out what's going

on in the system because it's clearly not working the way that it was intended.

Moving to 2006, there is a lot of changes that went on between the 2003 and 2006 period. The populations that we covered, we were no longer able to cover the adults that did not qualify for Medicaid, the higher income populations that we had served, and that was primarily the financing didn't work. There were some changes in some of the relationships with the Federal Government in some of the financing of those populations, but there was a lot of other activities, and I won't necessarily go through all those here.

But what we did, and again, when we took that pause in 2003, and I think it's important, when a lot of folks talk about managed care and they get in it and they hit some rough patches and then they talk about bailing altogether, and I think that's a mistake, I really do.

I think you need to learn from some of your failures and you can come back with a better product, and I think our story is proof of that. What you see here is, what we ended up doing, we had seven plans, all HMOs. We still had them at no risk at this point.

And those services were still carved out, but we had begun a process. We had begun a bid process and we said--and just for the record, it was the first time we had ever done a bid. In a lot of the discussion you hear around the country right now is, you know, they look at whether you do a bid or, you know, just kind of an open come-one, come-all as being a political decision. It's really not. It's a very practical thing and we've seen the experience of it.

When we started out, we basically had just put out a contract and said, Anyone who's willing to accept this contract and can pass the regulatory threshold, you know, with competent insurance, you can come and all of a sudden be a health plan.

Well, some of those folks really did not have the capability that was necessary to manage the care in

the way that we had expected. The analogy I use is a lot of people get into college, but not everyone does well. And we want the top performers.

So we finally, some 12 years later, have put out the first bids for some managed care plans. And when we did that, and before I go onto that, you notice still our satisfaction survey now is up to 87 percent. So people from the perspective of the enrollee, things were not as bad as what we were seeing on our side, which was a good thing.

So by 2009, we had secured--we had done the RFP. We had rolled it out, again, by region. We have three regions in the state. There's two plans in each region. All the plans were moved back to risk, and during that process, we decided we were bringing behavioral health back in.

A lot of the reasons why behavioral health was carved out, and I think this is the case where a lot of services are being carved out, they're not being carved out in the best interest of the enrollee. I think a lot of times people carve out services because of different fears or different groups that have interests, and I think the fear is interrelated to that.

So, for example, on mental health, some of the concern was, would our money get lost, which that again wasn't so much focused on the enrollee than it was about just control of the programs.

And we thought, you know, that's the wrong way to approach this. And so we had to take on a lot. We had to take on a lot of concerns in that regard in trying to carve it back in.

But what we had seen when it was carved out that just really tells you how these carved-out models and these disjoints really create problems for enrollees, we were constantly brought into the middle of officiating between an MCO and a VHO on how much of the care that was provided was behavioral in nature and how much of it was physical health in nature.

We had in the contract these things called bright lines that try to say which services were which and there's no such thing. I'm sorry. There's very, very light gray lines at best. And so, we finally said, Instead of playing this game and our focus and our energy not only at the Bureau, but also at the plans being one of trying to shift to one or the other, we said we wanted one entity to be responsible. And that's how we structured our bids.

And we spent a lot of energy of helping them understand what we meant by integrated. That did not mean that they couldn't sub those functions out, but the one plan that did bid and had a sub, we made it very clear about the need for co-location of the clinical staff.

It took awhile to get everyone there, but I think we've seen some good success in that regard, and actually have some really good stories of where we had found situations where you had individuals that were getting home health services that had behavioral health needs, but those behavioral health needs weren't being met because the home health agency and the folks that were interacting with them were not the people that were interacting on the behavioral health side.

You had situations where primary care doctors before didn't have relationships with the VHO, so for some of the behavioral health services they were providing or could provide, since they didn't have that relationship and couldn't get paid for it, that wasn't happening. So a lot of dysfunction there that we think we were going to resolve as we carved back in behavioral health.

And again, at this same time, we were also-- actually back in 2006, we told all plans we were going to require NCQA accreditation and we were going to require HEDIS reporting. We were the first state to mandate every plan. It wasn't an option. You had to get there.

So we took our plans on a pretty wild ride after we got out of that pause period. We learned from

our mistakes and said now we're going to up our game and we're going to expect more. So we started collecting all the HEDIS measures and again, our satisfaction survey that's been consistent over this time has continued to improve.

Moving to 2011, so we said, you know, after we brought the physical and mental health and behavioral health together, you know, and going back to what I was saying earlier about some of the designs of programs being more or less around systems as opposed to being around the enrollee, we said, What's another area that we have really failed in regards to the enrollee?

And it didn't take very long for all of us to come to the conclusion it was long-term care. That was a situation where you had nursing home services that were being paid for by the state. You had the plans that had responsibility for home health services and some private duty nursing services that were being used in lieu of long-term care services.

And then you had HUS services being managed by another agency, the Commission on Aging, that was administering that for us. And so, we had three different entities involved. And it was an impossible program design to be successful and we were putting our enrollees in a very difficult spot in trying to navigate a system that absolutely made no sense other than it just evolved that way.

And so, what we decided to do is we said we were going to integrate long-term care for the elderly and the physically disabled. That, too, took a lot of time and energy of getting all parties on board. Our thought process there was again similar to what we had with the physical and behavioral health, is the tools that were available to the MCO, you know, we have these standards and expectations for the MCOs to make such great improvements in the system; yet, we really limited what tools they had in their tool belt to really address the needs of the populations they were serving.

So when you're trying to meet the needs of someone that needs some in-home services and all you have is more costly home health and private duty nursing services as an option, and in some cases, you know, more expensive than--or in most cases, more expensive than some of the HCBS options we have, but that relationship didn't exist between them and what the Commission on Aging was doing.

We decided to give them those tools. And we've had some remarkable success in a very short period of time. As we've given those tools to the health plans, we have seen a really good thing play out for our enrollees and have actually had some really great stories of enrollees writing in or emailing in about Some of the great things that they've seen from this program thus far.

And our TennCare satisfaction survey then has reached an all-time high of 95 percent. I should also point out that by this time, we have had good experience with all the health plans that have been in place that we had bid that had won those bids, and ended up having the majority of almost all of our HEDIS scores improved in that five-year period of time. So, again, a lot of movement in the right direction from our perspective.

One other thing I should say, because you see--I think it was in this slide or the previous slide--one thing that we did when we were in that pause period, and I was listening to the prior discussion by the group that I think is an important thing is, when Billy was talking about having--he thinks there's a requirement that you really need to have three plans just in case one fails, just so you have the ability to react to that plan failing.

One of the smarter things we had done is we have one plan that is statewide, and that plan is--it serves two roles. One it's responsible for children in DCS custody, Children Services, our foster care children basically, and the SSI kids, and primarily because there's some movement. They don't necessarily

stay within our regions very well and there's a lot of movement. We don't want to have to move them from one plan to another. That keeps some consistency there.

But also, that plan serves the role of being the back-up plan. So in the event that any plan fails or we choose to remove a plan from service, we have an entity that we can move those members to. Unfortunately, we had a lot of experience of doing that in the early 2000s and we had to move lives very quickly to this back-up plan.

So we had a lot of experience, but it was a great tool to have available to you. Think of it as them being on retainer. And it's been helpful. So it doesn't put us in a situation to have to continue potentially with a plan that's not performing to our standards or expectations.

CHAIR ROWLAND: Darin, could you describe what the statewide plan is?

MR. GORDON: Yes. So actually, the plan and it's been with Blue Cross/Blue Shield. It's a managed care plan. We have a different arrangement. There is a risk component to it, but obviously there's not a risk component on the back-up portion of it because if they get members all of a sudden, it's hard to then expect that they--what we're looking for them to do in that situation is transition the members carefully, get them stabilized, make sure that it's blind to them what just occurred until we can come up with a new solution.

It started out just purely as an ASO arrangement, but we decided that with--on the children's component of it, that we can build in some performance expectations that introduced a risk component there.

It needs to be--it needed to be a big plan that had a statewide network. So there's not many plans that can play that role that are in our state, but Blue Cross/Blue Shield is one of them, and it's again

something that I would recommend everybody have some option there, because if you don't, like Billy was talking about, I think some folks are going to be reluctant to taking some of the more severe action that they may need to take if a plan is not performing at the level of the expectation.

So a little bit of an overview going through that time period. For awhile, we had very rapidly escalating costs that put severe pressure on the program. Again, our trend rates were easily--stayed in the double digits almost every year in the beginning part of the program.

We have significantly reduced cost trends now. We run in the three--well, typically under 4 percent, but usually closer to 3 percent trends, which is regularly half of the national average.

We had volatile health plans at the very beginning. We have very stable, well-capitalized health plans today and bring a lot more experience to the table, and I think that's very important. Again, going back to my college analogy, it's really helped us in some of the innovative things that they're rolling out across their state, we've been the beneficiary of that.

Very fragmented health care and design before. Much more integrated and, you know, we'll get to how--what our obvious, our logical next step is. And also, we had one of the most institutionally dependent systems in the country when we started this.

I will tell you that our system design that we put in place with our long-term care program, I think we have seen probably the quickest rebalancing you probably will have seen anywhere in the country with the way that we designed that program. And again, I think we've seen great satisfaction from that from our members.

Again, examples of some of the improvements that happened over time. The top left, you see basically cost trends. That's the national expenditures, health care expenditures. The red line is what ours

has been. Our trend line has been far better than what we've been seeing nationally.

Looking at different--we just picked a couple different things to look at from a quality perspective, member satisfaction. You can see the line as we're walking through the presentation. We're continually improving there. We're at all-time highs. You can see we've done a great job in improving our screening rates significantly from where they were back in the late '90s.

Again, as I was talking about, if you look at our HEDIS results, and 2011 is the same, we're seeing improvements in almost all categories across the board. Still have a ways to go, but again, moving very much in the right direction.

Lessons learned. I tried to fit that on one page and that's probably a tall order. There's a lot more lessons learned. And the good thing is, is we've had many states--we have been spending a great deal of time talking to many states that are venturing into the managed care world trying to avoid some of the mistakes that we had, but let me just go through some of these.

The procurement process and implementation, obviously, has to be well thought out. You think that that's a given, but I've heard some concerns of people's timelines on transitioning to managed care and I would agree with them that in some cases, those are a bit ambitious.

And what I fear is when sometimes you're more ambitious on that implementation, that it makes it appear that the model is a failure when it's really your implementation is a failure.

I will also say on implementations, when you do these types of things, there's no--some people's perception is that an implementation like this or a transition like this is flawless. There's no such thing as a flawless implementation when you're talking about hundreds of thousands of lives.

What you hope for is that you have a system set up that you can rapidly respond to issues as they

arise, not through the normal bureaucratic process, but you can make sure people get the care they need and you solve everything else on the back end.

And I'm happy to say, transitioning, when we transitioned to the new health plans in 2006, and also when we did the choice program, the long-term care program, you didn't read about that in the newspaper stories about people not transitioning well or people going without care.

And so, I consider that to be a success. We really put a lot of thought and energy into that and I think others should spend a little bit more time and energy thinking that through as well.

The contracts have to be detailed. And I would tell you that it doesn't mean that you have to do that and have to keep it that way, but when you're moving people into new programs, they need to understand what your expectations are, and sometimes the only way you can do that is through the contract.

Actually, when we went through the long-term care, when we started enrolling in the long-term care component, we actually sat down with the health plans as we were going through and designing what we were going to put in the contract, and that really helped everybody understand what our vision was for this new integrated product.

And I think that's an important thing to do. Sometimes you just write it and you throw it out there and then you're concerned about how people will respond to it. Well, it's because you weren't really clear on your expectations.

Another thing I've been telling a lot of different states about, the skill sets required when you move these populations into managed care. It's very different than the fee-for-service world. And you either have to do a lot of retraining or actually you may even need to find different types of employees to manage this, because you're moving very much to a regulator role and not necessarily one where you're processing

claims. And we learned that the hard way. It took us many years to kind of recover from that.

Talked about the partnership with the MCS when you're trying to design some of your new concepts. Contracts need to be routinely reviewed and amended. Every six months we do contract amendments. It's not because we've found all these mistakes. It's because we continue to learn. And it's not just a one-way street. It's not that we necessarily just say here's a contract amendment. Sometimes the health plans actually identify stuff where they raise good points about where there's some duplication in some of the requirements that we have. And so we, you know, try to respond to that as well, but you need -- the expectation, again, would be this continuous improvement, not that you had it right when you walked out the door the first time.

Thorough readiness review strongly advised, and we have whole teams that go in and really assist us in doing that, but that's a necessary component of this.

Folks again need to make sure that the leaders are really willing to hold the plans accountable, and that doesn't mean you're punitive, but you don't want to wait for a problem to blow up, so you need to make sure that you use the different tools that you have, whether they be liquidated damages, withholds, whatever the case may be. We don't start out in that regard, but we have those tools available to us in the event that they're needed.

We also have gone -- we started the whole process. Our contracts are very complex, and you have a lot of material coming in. Going back to what I was talking about from a person that's trying to manage this new system that sees, you know, these complex populations in managed care, you have all these reports coming in, and we used to try to manage that all through a very heavily paper-based system. We did get an automated system, so when the reports come in, we know they came in. They're then routed to the right

people. We see who gets them. We know if they opened them and they're using them, which, you know, is an important fact that needs to be researched if they're not. But that's something we put in place. Again, I don't think everybody thinks about that when they move to managed care, but that new shift in approach may require some new systems as well.

I talked a little bit about partnering with your MCOs. It really doesn't have to be a contentious relationship. It is your program. You're ultimately responsible. But a lot of the managed care plans that we've worked with actually have some really good ideas and some innovations to really help these populations, and you want to make sure that you have a relationship with them that allows them to bring those to you and allows those programs to be expanded as needed.

I'll just hit lightly on the items on the right so you all can get to questions. Making sure that you have the financial incentives aligned is obviously important. Again, where we had all the different programs in different areas, the incentives weren't aligned, and it's not necessarily that you saw people exploiting those different incentives. But, you know, when you have a situation where the nursing homes are outside of the responsibility of the managed care organization, not saying that we had evidence that they did this, but when a member went in the nursing home, it's less of a concern, obviously, to the health plan at that point.

I will tell you they're very interested now when they're responsible for the nursing homes, so when they're working on discharge planning that they've been doing a lot of work. What we talked about for a long time is all the hospital discharge planners know all of the local nursing home administrators by name, and now the health plans are helping them understand some of the HCBS providers that are out there and how those services could be key because the incentives are in line. Again, multiple tools are necessary in

order to be effective for meeting the needs of these populations.

Obviously quality of care is improved whenever the coordination of care is enhanced. A comprehensive approach is needed to assure quality and to track improvement.

The last one on that particular area, long-term care needs really some good outcome measures out there, and I know that NCQA is looking at some of those, but there's a lot of work to be done there. I think it's going to be needed more as we the aging population is growing, and I think people are starting to advance in the way that we deliver long-term care services and supports.

Integration of care. Nursing facilities services have to begin with the MCOs. I know some folks have portions of nursing home services in with the MCOs. They may have HCBS. You have to keep it all together because it sets up some perverse incentives otherwise.

The MCOs have to be the single entity that does the needs assessments and the care planning activities. I know that's been discussed by different states, and some have tried it differently, but we've talked to some of the states that have tried it differently, and they, after seeing what has happened, believe that needs to be the case; otherwise, again, you have some weird situations whenever that is dispersed outside and different entities are responsible for different portions of the needs there.

Then integrating the benefits just improves the system overall.

The next chapter, I'm going to let Patti talk a little bit about what we're doing on the dual integration, but, again, I think it's the next logical step. As you heard, as we are evolving and learning that all these programs that we've set up and really tried to divide the needs of the member based on the way we structure programs wasn't getting the job done, and so if you look at the next area where there's a major disjoint, that brings you obviously to the topic of duals.

* MS. KILLINGSWORTH: Thank you, and I want to step back for just a second before I talk about duals because I think it's important to understand how we got here as we've moved toward integration over time.

When we set out to integrate the long-term care benefit for the elderly and for adults with physical disabilities, we didn't set out to do it as a cost-saving strategy. We set out to do it for a number of reasons that were largely really member centric. So the first was we wanted to improve coordination of care for the member. We saw people struggling over accessing multiple systems. Benefits weren't being used appropriately. Quality wasn't what it could be.

We also saw people not really being able to avail themselves of lots of choices, particularly with respect to home and community-based services. We were about 98 percent institutional at the time that we really began this concept as it related to this particular population.

And then, finally, because of that we really wanted to rebalance the long-term care system. So while we didn't set out to save money, we did believe that we could serve lots more people in our long-term care programs using the money we had at a very difficult budgetary time, quite frankly, simply by serving more people more cost-effectively in home and community-based settings. And so as Darin alluded to, what we have seen are, in fact, significant improvements in all of those areas.

The focus really is on comprehensive coordination of care, person centered at the member level, very much person to person, face to face, on the ground. And we've seen lots -- with the integration of behavioral health as well as long-term care services, and those very comprehensive assessment processes, we've seen the identification of lots of gaps that we've been able to fill in that process. So lots of identification of depression and other kinds of mental health conditions that were going untreated or not

treated appropriately, and have really been able to improve care overall and not just as it relates to the long-term program.

We've also seen a shift of -- when we started out, 17 percent of this long-term care population was receiving home and community-based care. We're now above 30 percent of this population is receiving home and community-based care, so significant increases, and it's not just new people coming into the program staying in the community, which is important; it's also fewer people going into nursing homes, so lots of diversion going on and also some transitions that have happened. So hundreds of people literally that have been able to successfully move out of nursing homes and transition into home and community-based services. So really pleased with what we see.

And as we step back and we look at what is not working for members, this population, my long-term care population, is heavily dual eligibles, not surprisingly. So we have a little over 135,000 or so dual eligibles, full-benefit dual eligibles in our program. Almost 30,000 of those folks receive long-term care services.

So now I have a managed care organization that's trying to assess and plan and meet needs comprehensively, and all of the acute and primary care services are sort of outside the scope and purview of their authority. And it's very difficult to try to really do a lot of the things that need to be done for these members. These are folks -- or 75 percent of them have one of the conditions that we would typically mandate disease management activities for, but it's very difficult, again, to do disease management when a lot of those services are outside the purview of your control and responsibility. So we see them really struggling with trying to do a lot of the things that we think would really be beneficial.

It's also important that most of the nursing facility admissions are coming from hospitals, so dual

eligibles go into the hospital, they transition to a SNF facility for their 100 days, and then they move into the Medicaid long-term care population. And it's usually only then that the MCO gets brought into the mix because now Medicaid becomes the payer source.

That's not the way that it needs to work for members. We really believe that a lot of these folks could transition from hospital to home with effective home and community-based services, and there's a much better way to be able to manage those benefits.

So that's kind of how we got to this is the next logical thing from a member perspective to really be able to improve quality and coordination of care, and, yes, we do think deliver services more cost-effectively as well, primarily on the Medicare side.

So what we envision -- and I want to preface this by saying we're in the process of developing a demonstration proposal. This is not finalized. We're continuing to have discussions with stakeholders, but I'm going to share with you the vision as it exists today, which is that duals would receive their Medicare benefits from the same managed care organizations that provide their Medicaid services. So from a member perspective, again, we always try to make things as seamless as possible. When we integrated long-term care, people didn't have to change managed care plans. They stayed right where they were. That managed care program became responsible for their long-term care services. We want to do the same thing with duals. They'll stay right where they are. That managed care plan will become responsible for their Medicare as well as their Medicaid benefits.

Then that managed care organization would obviously be at risk for their Medicare as well as their TennCare services, and we're still working through sort of how Part D would work, whether that's partnering with Part D plan, whether that's actually having their own Part D benefit. But we want that

coordination of the pharmacy benefit because we understand how important medication management and medication compliance really is with costs.

MR. GORDON: And can I say something? When we were talking about -- if you remember those earlier slides where we saw pharmacy carved out, and a lot of people ask us why, one is -- remember when I was telling you the trends that were the 20- to 30-percent range early on? We're running about a 1- to 2-percent annual trend in pharmacy since we've been managing it. I basically told the plans that if they can come and tell us what they would do differently than how we're managing it and to where we could see even greater benefit, and the plans have been unable to do so at this point. But also from a consistency perspective, providers don't like different formularies, different plans. It makes it a lot easier.

We're not opposed to that concept, but, you know, the plans get the data. It's very important obviously that they get data very quickly for their members, which we've worked that out. So as we look at this and we're looking at the dual integration, we're just trying to figure out -- again, our model works on the Medicaid side, and we're just trying to figure out what we do with Part D in solving this problem.

MS. KILLINGSWORTH: From a member perspective, probably the most important thing is now they truly would have a single entity responsible for coordinating all of their benefits. So now assessments, care planning really could be comprehensive. Accountability for timely service delivery, all of that really could be very comprehensive, which for a member means increased satisfaction, we think better quality of care, we think better outcomes. We think the data will bear that out over time.

In terms of supplemental benefits, we're still thinking about what we could do. Obviously for this population they don't have a lot of cost sharing on the Medicare side except for the services that we don't cover under our Medicaid program. That might be something that we could also think about picking up.

The other thing that we think is really important, though, is we believe that this would really support our efforts to continue to rebalance our long-term care system. We think there are much better ways to use long-term care benefits for this population and that more effective transition discharge planning will really help us to get there, reducing costs on the Medicare side but keeping people in the community where they really want to be.

We also think that this will give us great potential in terms of the kinds of being able to measure outcomes. We thought when we integrated long-term care we were developing the quality strategy, oh, we'll just look at the SNP measures and we could apply those here. Well, no, you really can't when you don't have management of that primary and acute care benefit. So we think this will give us the availability of a lot of other kinds of health measures that we haven't been able to use with this population in the past in our program.

We do think, though, again, building on everything we've learned about selecting contractors and contract development and monitoring, it's all in how you define it. It's all in how you align the incentives. It's all in how you define the requirements and then how you manage to those requirements to be sure that you're really getting for members what you're looking to get for members as we move forward with this.

MR. GORDON: So I think we're -- questions?

CHAIR ROWLAND: Thank you.

COMMISSIONER CHECKETT: Well, first I have to congratulate Darin and Patti for the terrific work that you have done in evolving the TennCare program through the years. Many of us at the table remember when you were one kind of poster child, and it was, like, all right, there's 49 states and then there's Tennessee, and no one wanted to acknowledge you were in the Union. And now it is truly the

other kind of poster child. It's just terrific, and so I really know there's been a tremendous amount of work and leadership. So first my commendations on that.

It's just so fascinating to look at the progress you've undertaken, and I have a lot of questions, but I've decided to restrict myself to two. One, in your work on duals and moving and integrating your long-term care services, one of the things that we always hear from states is, you know, "The nursing homes won't let us. The nursing homes are too connected." So my first question to you is: How did you get the nursing home buy-in? Or maybe you didn't and you just moved ahead.

And then the second recommendation would be: Looking forward, what is the greatest obstacle and what can we as a Commission do in our recommendations to Congress to help you continue to move forward with your goals?

MS. KILLINGSWORTH: I'll do one and you do two. How's that?

MR. GORDON: Let me do one. I'll give you time to think on two. That's a little bit more challenging.

On one, I tell you, it really took making sure that you had everyone's buy-in within the administration. It really worked out where, you know, the governor basically had given a challenge at one meeting: What is the thing you're going to look back when your time in public service is over and say you wish you would have fixed? I mean, it instantly popped into my head. It was long-term care. And it was very much because nobody wanted to try to take on a very powerful nursing home lobby. And, obviously, in our state where we had such a high institutional dependence, we had 330 nursing homes, 95 counties, we did -- and this was an election year. So --

COMMISSIONER CHECKETT: And you are still a medical director.

MR. GORDON: And I am still a medical -- so basically I came back, and we cay asked -- I actually said, okay, this is our next area we need to do something on, and I said, "Patti, let's true to think about how can we fix that." And it's pretty funny because Patti, who was not a managed care person, not a big supporter of managed care originally, it took her a while, but she came back on her own and said that's what we do, that's what we know, and that's the right answer here.

So when we talked to the governor and the governor really said, you know, this is amazing. This is the one area a lot of people -- they want -- the type of service they want, like you think of emergency care because they want quick care, and they're saying -- but that's the more expensive care. Well, the thing people want here is HCBS, and it's actually the more cost-effective. He said, "I like that dynamic. You guys go for it and design this thing."

And he came out in his State of the State and actually made a big part about this and about his own personal story about his mother. And so we had the buy-in all the way up at the very top, and when we went and talked to the nursing home industry, it was not easy for them. But after they kind of gathered their thoughts, and we actually got other nursing -- some of their members who actually had diversified in the HCBS world and also talked about the need to do that anyway, they actually said -- there's just a couple of requests that they had, and they were actually things we were going to do anyway. So that made it very easy, which was not make this about, you know, renegotiation of rates. The benefit we had was really it's the rebalancing of it that would play out. So we would continue to set rates. We'd continue to determine -- we'd do the level-of-care determinations, and that was another request they had. But it was things like that that didn't necessarily make them support it, and they made this very clear because afterwards someone had said, "So this means you'll support it." And they said, "No. Hear my words very specifically. We

will not oppose it if we can have these issues addressed."

The other thing that we made very clear to people, if you think about it, you have this very large, growing aging population, and the way our system is designed right now, basically we only have a very costly method of meeting the demand, the way our system is designed, and we will not be able to accomplish -- we will not be able to do that. We won't succeed in doing that.

So we said let's get ahead of this and design a system that will give us some hope in being able to manage it more cost-effectively.

So we went through the entire process, and we also had people that had been trying to be successful in expanding HCBS in our state and failed time and time again, and we got them on board and said we're going to take you to this better place. You may not like the vehicle we're going to take you there in, but work with us, and they stayed together and worked with us very well, and we got through every step of the entire process from subcommittee to the floor without a single no vote.

So we've had a lot of states say how, because it hasn't worked, but it was the perfect aligning of a lot of different issues that really allowed us to be successful there.

MS. KILLINGSWORTH: I'll tag onto that just a little bit. At its core -- and it was the best piece of advice that we got from other states, was stakeholder engagement. It was really about talking to people and understanding their concerns and then trying to address those concerns as they moved forward. So we did meet regularly with the nursing home industry, with HCBS providers, with different groups representing members -- not all at the same time. We met many times with them differently because their concerns were different. But we did try to listen to everyone and to take actions where we felt appropriate.

In addition, a couple of the things that Darin mentioned, we mandated that the managed care

organizations contract with all nursing facilities for the first three years of the program. We set very stringent pay requirements to get cash flow, mandated lots of training and technical assistance around claims submission processes. So lots of things to really try to allay fears and concerns, and we did similar kinds of things from a contract and consideration perspective on the member side and for HCBS providers as well, you know, so that they could feel comfortable -- maybe not thrilled but comfortable about moving forward.

MR. GORDON: And as far as, I think, things that -- obviously the duals is probably the -- there's a lot of complicating factors. I think now with the current authority that they have, at least it hasn't been tested yet with the new office. Actually we were spending some time this morning trying to work through some of that. But I think even with the new authority that is out there to enable this better integration of duals, I still sense that there are some areas within Medicare, we're learning as we're going through this, that are not necessarily conducive to really promoting the true integration. But we're learning that as we go.

So far we haven't found many areas that have prevented us from really trying to move toward better integration, but I know it's partially the product of the way our waiver is structured and gives us some of that ability to do some of the things that we've done. I know others don't necessarily have some of that same flexibility, depending on what waiver construct they're under.

But one thing that we noticed when we were doing long-term care -- and, again, it gets back to designing programs around a member as opposed to around legacy systems that have been designed over time. It took a very long time for us to be able to get our waiver approved to do this model, and part of that really was trying to take two different worlds, the 1915(c) world and the 1115 world, and get those people together, and there was this constant pull to try to make us do the 1915 stuff as we were trying to bring in the 1115, again, trying to get people to think differently about how to approach the care.

We got there, so that's the good side of the story. It just took far too long to kind of work through that process. But I will tell you, as we're working through the dual integration, I have a feeling we'll encounter more challenges in that regard.

COMMISSIONER MOORE: I have a couple questions. One quick question related to the time frame that you were involved in when you started with the governor and you went through the movement to manage long-term supports and services. And then the second thing I want you to talk a little bit more about, in one of your slides you talked about the need for more standardized outcome measures in long-term supports and services, and you must have put in some, but I'd like to hear about what those are and where you would hope to see additional help and additional work in that area and where you might -- what you might know about anybody else who's doing that sort of thing.

MS. KILLINGSWORTH: So from a timeline perspective, our original conversations and analysis of design and all of that really began in the fall of 2007. A legislative initiative was launched with the governor's State of the State address in early 2008. Legislation passed in the spring of 2008.

We started a year-long waiver process with CMS. It took us a year to get to approval of our waiver. And then from there, which was -- I guess the final acceptance of the waiver terms and conditions came in August of 2009. Folks may remember that that's the time that H1N1 was hitting, and then we had sort of in the midst of what we thought could have been a six-month implementation time frame, two months which had significant holidays, so we ended up implementing in March of 2010, and we used a phased-in approach where we implemented in one region of the state in March of 2010, the other two regions of the state in August of 2010, minimally six months from approval to implementation of something of this size, and that's a phased-in implementation.

MR. GORDON: And another important nuance there that won't apply in every state, that's adding in long-term care services and support on top of already a stabilized physical and behavioral health system.

MS. KILLINGSWORTH: Right.

MR. GORDON: If you're doing it all at once, that's not going to be sufficient, but also during that period of time, again, understand we were sitting at the table with the health plans before we even started the implementation, working through what we were expecting. So it's deceptive, that six months. But if anybody's starting from scratch, trying to go that six months would be insufficient.

MS. KILLINGSWORTH: The year that we were in waiver negotiations with CMS, we were also in contract development talks with the managed care organizations, so that really it was a matter of finalizing the contracts, working them through the approval process and all of that, and then really moving toward readiness review and implementation. So that was the time frame.

In terms of outcomes, it was the biggest struggle for us, you know, because a lot of the things we thought we could sort of point to it turned out we really couldn't point to yet until we could move to even a more integrated program. So we kind of have a hodgepodge, if you will. We built on our existing quality strategy, which is very much an integrated quality strategy, but added in things that are specific to long-term care, and we borrowed some from sort of the 1915(c) quality framework where we look at the kinds of things that we look at in those programs around level of care and service planning and health and welfare kinds of assurances. We built some of those into the program. We did manage to find a couple of SNP measures that we could sort of kind of use. But we've had lots of conversations about really the need for more standardized kinds of measures for integrated programs, particularly those programs that have

long-term care and now that have dual eligibles. And I think really with the integration of the dual benefit, it will open up some new doors for us that we haven't had.

MR. GORDON: Also, those measures, needing to have those measures, where it's being consistent across states would be helpful, because, again, if we get them and we see them for us, you don't know if that's necessarily good or not. It would be helpful if you had others to be able to benchmark off of. That would help us a lot as well.

COMMISSIONER MOORE: And I assume you also built off of your managed care for elderly and disabled, just the physical side of things. Do you have any national or other standards that you used for that or do you have your own?

MS. KILLINGSWORTH: We do all HEDIS and CAHPS, so all of the HEDIS measures the plans have to collect data on.

MR. GORDON: Even the voluntary --

MS. KILLINGSWORTH: Even things that are voluntary, they have to collect. And then we do the CAHPS surveys as well.

COMMISSIONER HOYT: I'd like to try and follow a threat that I think started in 2006. I don't know whether these dots connect or not.

I think you mentioned a slice of the adult population was pulled out of the capitated contracts. I don't know whether that was childless adults or uninsured adults, however you describe those, and then notice in 2009 the plans are back at full risk, and behavioral health is carved in. The adult population that was removed, so to speak, were they high needs in the behavioral health sense? And now in 2011 do you have adults or anybody else who's not covered by the capitated --

MR. GORDON: No, everybody is still covered capitated. That was actually where Tennessee had covered individuals that were not eligible for Medicaid, so we were covering anybody at any income, and they were adults that were uninsured. So we can no longer support doing those after a lot of different factors that went into play. And, actually, that people is -- actually, the information we have on that population, or we had then, it's quite informative in the exchange discussion and also some of the Medicaid expansion discussion. But I'd tell you, two-third of them looked like a TANF-eligible individual from an experience perspective and about a third of them looked like your disabled population. But two different issues. Everybody's still 100 percent in managed care, those that we cover.

COMMISSIONER HOYT: So all your Title 19 population is in the capitated contracts and --

MR. GORDON: And have been since nineteen-ninety –

COMMISSIONER HOYT: -- no more uninsured or --

MR. GORDON: Yes. We're just not able to cover the -- it's some of our adult waiver population that we can no longer cover.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: Well, I would echo Donna. This is remarkable stuff. Those of us who read the 1994 waiver, it's a new day.

I'm intrigued by the plans and the notion that you've kept the small number of plans and rolled behavioral health into them, rolled long-term care into them. Many people argue that commercial plans are incapable of doing that and would really question the viability of that. Could you talk a little bit -- you told us that Blue Cross-Blue Shield was the Statewide one. Could you tell us more about who they are and --

MR. GORDON: Yes --

COMMISSIONER RILEY: -- what Medicaid benefits --

MR. GORDON: So when we bid it, and again, we bid it both -- we did it by regions. We rolled it out again, learning from our 1994 mistake of trying to do it all in less than six months Statewide, and we did the bids first by the middle, then we went to the East and then the West, and it ended up working out this way. I'd probably do some things a little bit differently. But United won -- ended up winning in all three regions, Amerigroup in Middle Tennessee, and then Blue Cross-Blue Shield in East and West.

I would tell you that even the plans that actually had wholly owned subsidiaries that have behavior health experience needed some help in the integration of those services, and I think they would admit that. So they had experience with these populations or subsidiaries, but they still did not necessarily get what our vision was on actually being integrated, not just two different entities separate, and that took some time in the very early on about the colocation and seeing where it looks seamless. And I would tell you, Blue Cross-Blue Shield, even this far out, just -- they are working even harder now to figure out how to make that look more seamless to the provider, to the enrollee with a subsidiary. Or they sub it out with value options at this point.

I would tell you, you know, I've heard that comment a lot with a lot of the different services that these people receive through managed care and I just don't buy it. Our experience contradicts it 100 percent. Does it take the right partners and does it take a lot of explaining of what your expectations are and helping them understand the system? Absolutely. Some of those folks actually hired individuals that worked in those communities serving those populations to help be some of the care coordinators.

So it's a challenge, I think, but it's one that can easily be overcome if there's a lot of good

communication and expectations are clear. And now some of the things that they are doing, you know, and to give examples, working with bringing in different teams of different professionals going out into the community to meet some of the folks with behavioral health needs, partnering up with some community mental health centers and colocating some nursing staff so that primarily they see the people more than the people want to go actually to the primary care provider to get some of their care.

They are being pretty creative and flexible in meeting the needs, and I would tell you that when we integrated it, something we didn't have before, we didn't have any quality measures. But since integrating, every year, we've seen our behavioral health quality measures improve, as well.

COMMISSIONER RILEY: And these plans, do they have a sub-plan that's a Medicaid-only plan, or can you tell me something about the commercial mix?

MR. GORDON: United, obviously commercial, and they have United Behavioral Health, which is what they've kind of brought together, and that's in, I think they now call it the State and community or State and local community portion of the United products. Then Amerigroup is pure play Medicaid. And then Blue Cross-Blue Shield does have both commercial and non-commercial in our State.

MS. KILLINGSWORTH: And then from a long-term care perspective, two of the three had long-term care, managed long-term care experience in other States. I think they would say that we set the bar higher. I think they're probably right. When we were developing our contract requirements, we looked at a lot of other managed care contracts and found care coordination requirements usually being a few pages. I think ours are 50. So we expect a lot, but we're really clear about what we expect. And they would say and have said that it's made them better and that they're taking some of the things that they've learned and implementing them in other markets.

MR. GORDON: And what we've heard is our standards, when they look across, like the two plans that are in multiple markets across the country, that our standards, I mean, just across the board, are higher than what they see in the other markets, and so the benefit to them is they've said, okay, we've been able to make it work with Tennessee's expectations and so they're rolling that out to all their markets so they'll look even better in the markets where they're at where the standards are not necessarily as high.

CHAIR ROWLAND: It would be helpful if you could provide the standards so that the staff here would have a better idea of what your level -- bar is.

MR. GORDON: Sure.

CHAIR ROWLAND: Burt was next.

COMMISSIONER EDELSTEIN: I just wanted to circle back for a moment to Judy's question about performance standards, because you addressed it well regarding long-term care population, but I'm particularly interested because it's our focus now on the disabled population. So what are the lessons learned that we can use as a Commission and where are we with performance standards in care of the disabled?

MS. KILLINGSWORTH: In terms of, again, standardized outcome measures, I think that's a work in progress and I think it's something that all States are grappling with.

But in terms of just defining performance expectations and managing to those expectations, I think the most important thing we know about folks with disabilities is that they need lots of care coordination. When you sort of leave a member out to find their way among fee-for-service systems or even very fragmented managed care systems, they're not going to have great outcomes and very high quality of care. So the cornerstone, really, that we think of when we think about integrating this population is that care

coordination component, really comprehensive care coordination, not just looking at even physical and behavioral health services and long-term service support needs, but also even looking beyond that. Our managed care programs are getting involved in housing. They're getting involved in all kinds of things that they haven't gotten involved in before because that's a part of helping people live successfully in the community. So it really is very member-centered.

Now, the performance expectations, then, are around how you expect that to be delivered. So we look at all sorts of things from the timeliness of certain activities, and we have fairly stringent time frames, to making sure that people get the services they're supposed to get, to making sure that contacts with care coordinators happen periodically, member satisfaction, all sorts of things like that. And what I think we want to be able to get to in these sort of standardized measures is really better health outcomes that are more reflective of the kinds of things that pertain specifically to people with disabilities and then also functional outcomes and really being able to monitor our ability to help people maintain their independence for as long as possible over time.

COMMISSIONER EDELSTEIN: So this is the whole area where health and social services all start to blend together --

MS. KILLINGSWORTH: Right.

COMMISSIONER EDELSTEIN: -- and I'm wondering, how far do -- because I'm just not familiar with these -- how far do CAHPS and HEDIS take you, and are you in the world of developing novel measures, and what kind of studies or work is underway to do this?

MS. KILLINGSWORTH: Yes. So HEDIS -- there's currently some things that are targeted to long-term care populations that really go beyond sort of the typical -- there's a CAHPS survey now for

nursing homes. There's a CAHPS survey close to being ready, I think, for folks who are receiving home and community-based services. And that gets beyond just what I think of as being true sort of consumer satisfaction. It looks at various aspects of quality from a consumer's perspective. It's very -- I think it offers a lot of promise. It aligns in a lot of ways with the participant experience survey that's been used in 1915(c) programs for a while.

And I think there's a lot underway to build out HEDIS measures and some other kinds of programs that are looking at trying to build out some other more functionally-based kinds of measures, but right now, there's just nothing that you can point to and say, that's what we all need to be using to really measure quality outcomes for these populations.

MR. GORDON: And I don't think it's a State-led initiative that's really going to get you there. One State doing it -- then again, it goes back to my issue, is it makes it very complicated to really find out how you then compare to others and whether or not what you're reporting on is good or bad. And so, ideally, I think organizations like NCQA that have such a robust, such great size behind every little measure that they do, they're well situated to help us solve this problem. We and others have been encouraging them and organizations like them to take on this, and they know -- and there is some work being done there, but I do think it needs to be someone that brings that type of rigor behind the development of these measures.

CHAIR ROWLAND: Thank you. That's a good, helpful suggestion to us.

Andy, you were next up.

COMMISSIONER COHEN: Thanks. Great presentation. Thank you so much.

I wanted to talk a little bit about the behavioral health carve-in and population, so I have a couple of

questions there. The first thing is I'm interested in sort of understanding in your experience how integration of physical health and behavioral health, but this is probably also relevant on the long-term care side, at the plan level and at the financing level translates into better sort of integration at the delivery level. I think you spoke that in the long-term care setting, at least, it really sort of almost immediately led to proliferation of home and community-based services and other sorts of things. You know, one of the things that has been, I think, viewed as like a kind of, I don't know if best practices is technically the correct term, but sort of a goal is to do more integration and colocation, I will say, of behavior health and physical health.

So I'm curious whether that's happened, quickly, slowly, what other policies you may have had in place to facilitate that, or are you thinking about to facilitate that, or if it really is the structure drives it. So that's my first question.

The other thing that is a little bit more specific is I just wanted to ask, do you -- in terms of your benefit package on the behavioral health side, it seems like care coordination maybe covers a lot of things that are sort of social service linkage related, but do you cover any non-clinical kinds of services and can you talk a little bit about the sort of benefits or challenges of doing that through a managed care arena.

MR. GORDON: On the first points, and I've been on a lot of different groups talking about this particular issue, and it's interesting -- actually, Sara was -- just recently, we were having this discussion about is there this silver bullet on how to solve this problem of this integration and how to get this done, and I think the answer is no, and the reason being just looking at our State, and I talked about this at that meeting there, is if you look at our Upper East Tennessee is in some cases closer to Canada than it is to Memphis. Each market functions very, very differently.

But one thing is true. You will not be successful, I think, in any of the approaches until you first -- you solve the integration at the payer level, and it was actually an area that I had to do a little bit of research whenever we were trying to figure out what we wanted to try to do differently and I looked all over the country and there was that constant thing, is no matter what you try to do, if you had two different payers, and this is kind of what led us to -- on the duals, it's the same type of problem -- two different payers, different sets of rules, relationships that don't exist naturally, and then you expect it to work well. You will fail. So I think integrating at the payer level sets up a system and an environment where things can happen.

Then getting down at the more local level and seeing, then, what does that mean at the clinical level, you know, we had all sorts of people present at this panel that we were at just a few weeks ago and talk about some things that were successful and some things that were not, and I brought up the point is that I personally in Nashville cannot think of every answer within Tennessee, what is going to make most sense in that local community. And we've seen that to be the case.

So, in other words, if I force colocation of a nurse in a community mental health center and I force that, then if the culture doesn't adopt that, then it will be a failure, too. And instead, what we have seen is some community mental health centers that have been really creative and innovative and said, I would like to do this, and now they can and they have. Then they said, I have some members that don't come in here. They have other complicating needs. And so they came up with, actually, working with the health plans in coming up with a multi-disciplinary team going out to those members, and they are trying that out there.

In some areas of our State, you know, if you look in the Memphis area, for example, when we had

typically historically low utilization on both the mental health side but also on access -- not access to primary care, but people accessing primary care -- we went down there and said, what is going on? What's the deal. Actually, it wasn't until I went and met with some of the large African American churches down there and talked to some of them and they said, I'm sorry. Our members, there's fears of going and stereotypes of going to some of these different places, and said, instead, work with us. There's trust here. And that's where we can help meet the needs of these folks. And so in that market, that's what works.

Our system allows for that great deal of variability about how people need services. Again, it's that mentality again. We can design a program and say, why aren't people working within the program, or say, set up a system that allows a program to wrap around and evolve what's appropriate in that local community, and we've been seeing that great variability.

And I think, what's the right answer? All of them. I mean, there's not a single right answer, and I'm afraid if we tried to dictate one, we'd be a failure in some markets. We may be successful in others.

COMMISSIONER COHEN: I asked about the non-clinical services piece.

MS. KILLINGSWORTH: Yes. So particularly if you look at duals, the behavioral health expenditures are the second largest, right behind long-term care, and a significant piece of that, more than a third, is really -- it's a non-clinical service. It's mental health case management and it's a very diverse service that encompasses some of the kinds of things that you're talking about.

I think we're working to try to bring better definition to that service and to understand exactly what's being delivered to the member and just sort of standardize perhaps some of the qualifications and requirements. But it's clearly an important part of helping folks with serious mental illness continue to live successfully in the community and utilizing services appropriately at the time that they need them.

CHAIR ROWLAND: Okay. David.

VICE CHAIR SUNDWALL: I'll be very brief, but thank you again for your presentations. It's amazing to see, as Donna said, the cycle you've gone through and public kind of impression of what you're doing.

Andy beat me to the punch. I was actually going to comment on the colocation of mental and primary care. I'm a clinician still. I see patients a half-day a week and we three years ago colocated and had mental health services. I cannot tell you how welcome that is. There's no clear line between behavioral and physical health, like you said, and for me to have on-site someone with whom I can consult on psychotropic drugs, where now they have become so many and varied I really am handicapped if I don't have that, and I just can't imagine, although I don't have data to back it up, that we don't have cost-benefit from having that colocation, much less costly mental health services, often a separate clinic at a separate place. So I commend you for that and think that that's something I hope the Commission can emphasize, that this colocating behavioral and physical or primary care would be very, very constructive.

MR. GORDON: And I should say, some of the -- again, obviously, on the physical side, there's been colocation of behavioralists, which -- and again, it's been naturally evolving, and in some cases being promoted -- in the areas where people don't want to do that, we have -- some of our health plans have actually worked in developing those relationships and helping those clinics understand, here's some of the behavioral entities in the area that can help meet your needs and they've helped foster those relationships.

But very early on, I would say within the first several months, which was really, I think, pretty impressive that some of the larger clinics said, look, it's hard for me to meet some of the needs of my members when they don't have shoes on their feet or they don't have a jacket to keep them warm, and

health plans, unprovoked, said, I'm going to put a worker -- I'll pay a worker and we'll put someone in your office that can help them, plug them into accessing some of these additional services to help them out so you don't have to worry about that.

CHAIR ROWLAND: Great. We have Richard and then we have Sharon.

COMMISSIONER CHAMBERS: I noticed in your presentation you talked about back in 2006, you were the first State to require NCQA for the health plans, and you have seven at the time. I'm just curious how big of a lift that was for plans. My plan is going through it. Many States, I assume, don't require. California doesn't. We're going through it voluntarily. But it's a real call from a health plan's perspective as to whether to pursue that or not because of the expense and the big impact on an organization going through it, and I'm just curious as to what was the reaction at the time? How tough was it for some plans, and do you think it really made a big difference? Would that be a recommendation that, like, this Commission would make as in quality performance?

MR. GORDON: It was. Well, it was on the same day that we broke a lot of news to them that we were going to be rebidding out, or we were going to bid out for the first time all of the networks and we were going to require NCQA, so there was a lot of bad news from their perspective that day, so it's hard to discern the grimace on their face, which was related to which.

But what we -- I have shared with others, it's different when you're transitioning with existing plans to making that requirement versus requiring it new, because if you're requiring it new, they can think of that from their perspective when they're doing their bids and build it in. So what we actually did is built up a structure where we would help if they had different benchmarks with some of that cost, offsetting some of that cost, invoiced cost associated with not all of it, but really help offset some of that, and also, based on

some of the results would determine how much, you know, whenever that information comes in, if we would even pay out more. And that was, again, to help bridge and transition them.

As we told them, we're not going to pay for all this. It's the right thing to do. We always thought we were paying for quality. And so -- but at the same time, we recognized that was a different requirement than what we had been talking about before, so we helped bridge that requirement.

The only push-back we really got, then, after we got over that hurdle, was interest in trying to do like other organizations and, you know, like, you're right, then where are you. Well, that's fine, but we want consistency across the plans for our benefit. And so we got past that. It didn't take very long for people to understand that made sense.

CHAIR ROWLAND: Okay. Sharon.

COMMISSIONER CARTE: I noticed that you showed improvement on your children's HEDIS measures and I was wondering what you attribute that to. Is that improved access? Were there incentives? NCQA?

MR. GORDON: I think -- you know, we heard some of the comments from the earlier group, too. It's when you use -- and I'm a data junkie personally, but if you don't use the data, it's useless. I think it's great when we issue the HEDIS report and it shows all the plans and how well they're doing and you have the green and the yellow and the red and it's showing. That peer pressure helps tremendously when they're publicly shamed into performing better. And so I would encourage everyone to do that as frequently and often as possible.

But I also -- we do have some performance bonuses that are related to different improvements in different areas. We've mimicked a little bit of what New York did, where they pick a couple of different

measures and you get different incentives for improvements in these areas, and once we've seen a little improvement there, then we switch them. So once you've gotten your process to evolve to do better in this area, then we'll move you on to another area to try to seek improvement. So I think that's helped.

But, again, I think helping everybody see, this is what we're going to be measuring you on and help gauge how well we think you're doing as a plan, that's really helped, just something as basic as that.

CHAIR ROWLAND: Mark, and then Judy.

COMMISSIONER HOYT: Back to behavioral health again for a moment. I just wonder if you had observed any difference by plan in the data you collect, or maybe the surveys, between those that absorb the behavioral health responsibility or function in-house and somebody, I don't know if it was the Blues, outsourced it to VO.

MR. GORDON: Differences from a data perspective?

COMMISSIONER HOYT: Satisfaction, level of service delivered --

MR. GORDON: Uh, not really. I think, again, as the Blues kind of recognize, there's still some -- what we would like it to be from people's perspective is it's Blue, not two different entities, and so they have some work to do there because they still somewhat function like that and I think it makes people think, again, in two different worlds, and we're trying to let them think in one.

But we really haven't seen any noticeable difference there, just more anecdotal on the ground, you know, one seeming more seamless than the others.

I will say on the behavioral health side, the thing that we had to do right off the bat, we had to change a lot of the reimbursement methodologies that were in place with the providers. A lot of those were case rates for a while, and really what ended up happening is we'd get the minimal encounter data just

to trigger the case rate, and so we really -- that wasn't helpful to anyone, and so we really did force the plans to really do -- you could use case rate, but it had to be in a rare exception. Primarily, we want the data. And so as we did that, we started getting more robust data, which then led to us being able to report on some of the quality measures there. But that wasn't a symptom of how the plans were structured. It's more or less a symptom of how the reimbursement methodologies had evolved over time.

CHAIR ROWLAND: Judy, last question.

COMMISSIONER MOORE: Darin, there are so many States that have announced in the last, really, six or eight months that they're going to go whole bore ahead on managed care for elderly and disabled populations, and in many of those States, they have very little managed care. They may not have very much experience with managed care. You're in a very different position, and I assume you've actually heard from some of those folks who would like to know more about what you're doing.

MR. GORDON: Yes.

COMMISSIONER MOORE: And there is a certain amount of fear on the part of observers of all kinds about how this is going to play out over time, even though we know a lot more about managed care than we certainly did in the early 1990s.

I'm wondering if you -- what you would say to us in terms of a priority for us as we reflect on this and look at it, but also even to other States about what they need to really have down cold in order to make this work for beneficiaries as well as for the State and what cautions you might have for us.

CHAIR ROWLAND: And we'd be glad to take your answer now and a follow-up --

MR. GORDON: Sure --

CHAIR ROWLAND: -- if you would give us more --

MR. GORDON: I'll do a little bit of a follow-up. I smile when you say that, because we have probably talked to no less than 12 States and have spent hours working with other States talking through. So the good thing, I would say, and I've been around Medicaid for a while and I hadn't seen this before, which we failed to learn from one another as well as we should, but I will say I've had no short of 12 States reach out to us and try to talk through and understand and, you know, again, borrow and steal from one another contract language on how we structured things, some of the challenges we had as we worked through.

So the thing I've noticed, it's like you said, it varies State by State. It's different issues. I have cautioned a lot of States on the time frames that they're talking about, and I understand why they're talking that way, but my fear is, again, that people will perceive a failed implementation as a failed concept, and I think that would be a huge mistake because I think as we've shown, if you stick with it and you learn from those mistakes and you continue to tweak the program, that it can actually be the best thing that's ever happened to the beneficiaries we serve. But I have that very same concern, that the pressures that they're feeling as Medicaid directors and having to do this in such a very short period of time may have unintended consequences. But, again, it varies State by State. There's not a single answer I could give to what would be the best thing you could do.

The good thing that I'm seeing that's happening out there is a lot of the folks that have been in some of the States, have done managed care for a while, some of the consulting groups that have been out there, are some of the ones that are helping those other States, which is good. They've learned from some of the stuff and they've actually stolen from some of the stuff that we've done and others. That's actually a good thing, and I never really do plugs for consultants, so that's probably my one time for the next ten years.

But I really do think that's one benefit that we're seeing, it's some of the folks that actually have some experience and not folks that really haven't really been involved with this type of population.

But, yes, I'd be willing to follow up with the group on some other things, just compiling some of the stuff we have. As a matter of fact, I have a State coming in a couple of weeks. They're coming in to spend a couple days with us to walk through and understand it better, and there's a couple of States that want us to come visit their State and walk them through some things. So I think the right conversations are happening. I just hope that time will allow for those conversations to actually be put into practice for a successful implementation.

COMMISSIONER MOORE: It just needs to be institutionalized more, or thought of in, you know, sharing of best practices and innovations so you aren't continually reinventing the wheel --

MR. GORDON: Absolutely.

COMMISSIONER MOORE: -- every time you turn around.

MR. GORDON: Absolutely. I 100 percent agree.

CHAIR ROWLAND: I think we could keep Darin and Patti here for two or three days, so Donna, if you have a quick wrap-up --

COMMISSIONER CHECKETT: Well, now I have a wrap-up, anyway.

[Laughter.]

COMMISSIONER CHECKETT: Well, again, I think, obviously, we could keep you here for a long time and we're excited and appreciative of your work and hope you'll come back. But before you go, fraud and abuse, program integrity, we had, as you might imagine, a scintillating discussion on that topic yesterday, and I just wondered, how are you addressing the CMS requirements and concerns on program

integrity given that you're all managed care?

MR. GORDON: That is challenging. It was challenging particularly like when the RAC contract, you know, the concept was put out there and we put out a bid and then later were told that, oh, that doesn't apply to managed care. And then I said, well, I've already got a bid out there, I'm going to do it anyway, which caused some pain and consternation.

It is more challenging. I will say a lot of the mistakes we made in 1994 with a lot of areas which were, now that we've contracted it out, that we don't have to worry about those things anymore, and that it's full risk, so they have the incentive. That scares me. We found that doesn't work.

It's more challenging from the respect of trying to find those safe harbors of when is it adequate time for the plan to have really done the things they need to do to recover those costs versus then when it's free game for us and our contractors to go back and get it. And thus far, it's been painful in some of the discussions, but I think we have come up with what everybody perceives is sufficient time for their processes to work and for them to recover from those activities versus when it's ours.

COMMISSIONER CHECKETT: Mm-hmm. But --

MR. GORDON: And I think it actually sets up good incentives, to be honest with you, knowing that you have this other entity out there that's going to get it if you don't. I think it's started to put more pressure on the plans to be even more active in that regard.

COMMISSIONER CHECKETT: Okay. Thank you so much.

MR. GORDON: Thank you.

COMMISSIONER CHECKETT: And congratulations again on a great success story.

MR. GORDON: I appreciate it. Thank you.

CHAIR ROWLAND: I want to thank Darin and Patty for joining us. You haven't heard the last of us and we hope that we will continue to be able to hear from you, and I think you've given us a lot of helpful suggestions for this outline on one of the key areas that we want to comment on in our March report, which is high-need populations and how to better integrate their care and care for them. And the Commission, I hope, will be looking at this particular chapter with very strong evidence to put in from the many discussions we've had, and this is one of the areas that we can strengthen some of the chapters in our report by bringing in discussions like the one we had today. So this has been very helpful --

MR. GORDON: Thank you.

CHAIR ROWLAND: -- and I thank you very much.

MR. GORDON: Thank you.

CHAIR ROWLAND: And this is the time of our meeting where if the public listening to us, watching us, has any comments they want to share with us, please come to the mic. Any takers?

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: Seeing that everyone, I think, has heard so much great discussion there's no additional comments, I wanted to just quickly talk a little bit about the fact that we are going to be moving forward toward our March report and to just highlight some of the areas that we're looking at.

You've heard many of the issues that we've covered over the last day and a half are really the features that we want to build in to our March report, looking especially based on this discussion on how to handle high-risk, high-need populations, delving more into the people with disabilities who depend on the Medicaid program for their care, the way in which they get their care.

Looking at access and quality, we've begun to look at how to build and review the quality measures in place and look especially at how those might be applying more broadly to long-term care. We've talked a lot about financing and about how Medicaid is financed, but also gotten into some of the issues with regard to CHIP financing for a chapter there, and I think obviously, after our scintillating discussion yesterday, really need to feature some of the program integrity issues that we discussed, and then begin to look forward at where the Commission's work can be going over time for June.

We've had a great deal of discussion about maternity care and about CHIP and about the future of CHIP as well as about duals, dual eligibles. And I think all of those topics need to be staffed out and developed for our ability to address them in the June report, hopefully, and also to begin to look at a discussion we started yesterday of how innovation gets built into the Medicaid program itself, how that interacts with the Innovation Center at CMS. So all of these topics are ones that we hope to pursue in greater detail.

So with that brief overview of where we're headed, we can call this meeting adjourned, though I would like to have the Commission members pause from a few minutes so we can give them some work assignments before they flee the town.

Thank you very much, and thank you, for those who joined us, for listening in and being such a great audience, even if you didn't join us for some comments. Thank you.

[Whereupon, at 12:31 p.m., the meeting was adjourned.]