MACPAC
Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

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

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1:09 p.m.

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

CHAIR ROWLAND: Okay. If we can please come to order. We are pleased to open this meeting. The purpose of our meeting today is really to talk through the chapters for our March report to the Congress, to discuss the content of those chapters, whether they're on track to where we want them to be, and to begin to formulate some potential recommendations that might accompany some of the content in the chapter.

What we plan to do this afternoon is to go through each of the chapters by reviewing the content of that chapter and then talking about the changes the Commission would like to see made, any of the issues that are raised in the chapter they would like to see further discussed, as well as to look at items that may be missing from those chapters, and then to discuss any potential recommendations that we would be embracing and, if we want to go forward with, would be voting on in our February meeting.

So we're going to begin our discussion today with the chapter on Medicaid and persons with disabilities. It's one of the main focuses that we have identified for this March report, and it is going to be a central piece of our analysis of one of Medicaid's high-need and high-cost populations.

So I'm going to turn to Christie and ask her to start by walking us through some of the key content of that chapter and then have others chime in as necessary, and the Commission should really work very constructively toward giving the staff the feedback they need to get this chapter into shape and then to discuss the recommendations. Christie?

MEDICAID AND PERSONS WITH DISABILITIES

* MS. PETERS: Thank you very much.

The Commission has been focusing on persons with disabilities over this past year. You have heard from a variety of speakers, including CMS officials, state Medicaid officials, beneficiary

representatives, and representatives from programs designed to serve persons with disabilities. It has been emphasized during these presentations that persons with disabilities are a high-need population that is heterogeneous. Subgroups of persons with disabilities differ in health status, service use, and expenditures. It also has been emphasized that one-size-fits-all policymaking does not work for this Medicaid eligibility group.

The MACStats section of the Commission's June 2011 report to the Congress highlights the impact Medicaid enrollees with disabilities have on program expenditures. Half of the program's spending growth from 1975 to 2008 is attributed to Medicaid enrollees with disabilities. This eligibility group accounts for a disproportionate share of benefit spending as the most expensive eligibility group both in terms of total spending and per enrollee spending.

This Venn diagram illustrates which groups of enrollees with disabilities we are addressing in this March draft chapter. As you see, we have two circles representing Medicaid and Medicare and an ellipse cutting across the circles representing individuals qualifying for Medicaid and/or Medicare on the basis of disability. The cross-cutting ellipse of individuals with disabilities shows different subpopulations.

CHAIR ROWLAND: [off microphone] If I can just interject, the handout is [inaudible].

MS. PETERS: Okay. So looking up at the diagram and looking at the ellipse of individuals with disabilities, moving from right to left as you're facing the picture, the first group is individuals who are only eligible for Medicaid. Individuals with disabilities who are only eligible for Medicaid. We refer to this group as the Medicaid-only group.

In the center you'll see there are individuals with disabilities who are dually eligible for both Medicaid and Medicare, and then on the far left, there are individuals with disabilities who are eligible only for Medicare.

The focus of this chapter is the eligibility group all Medicaid enrollees with disabilities as a whole

and the subgroup of enrollees with disabilities with Medicaid-only coverage. So looking at the diagram, the eligibility group of Medicaid enrollees with disabilities means the 5.6 million enrollees with Medicaid-only coverage -- the group on the far right -- and the 3.5 million enrollees with disabilities who are dually eligible for Medicare and Medicaid -- the group in the center of the ellipse.

In addition to looking at the eligibility group as a whole, the chapter provides information and data specific to the 5.6 million Medicaid-only subgroup. This group of enrollees includes persons who receive Supplemental Security Income benefits. They're eligible for the SSI program. They have limited income and resources. They meet the federal definition of disability, and they may have limited or no work history.

This eligibility group also includes individuals who receive the Social Security Disability Insurance, SSDI. These are individuals who have a work history, who are receiving DI benefits, and who are in the 24-month waiting period for their Medicare eligibility.

Medicaid provides both acute-care services and long-term services and supports to this group of enrollees, both the Medicaid-only -- excuse me -- to the Medicaid-only. That's what I meant. Okay? While information and data on the 3.5 million enrollees with disabilities who are dually eligible for Medicare and Medicaid is used for comparison purposes in this chapter, more in-depth information and data specific to this subgroup of enrollees with disabilities will be presented in the Commission's June 2012 report, which will include a chapter on all dual eligibles.

The chapter is divided into four sections: population characteristics, Medicaid service use and expenditures, quality measures for persons with disabilities, and key issues. Staff will be highlighting each section for you in more detail.

In addition, the chapter includes an annex that contains a table describing legislative milestones in Medicaid coverage of low-income persons with disabilities and a table identifying standardized quality

measures most often reported for high-need, high-cost populations.

The population characteristics section of the chapter discusses the heterogeneity of the Medicaid enrollees with disabilities. It describes federal disability programs -- that's the SSI program and the SSDI program -- the federal definition of disability that must be met to qualify for benefits in these programs, and the disability program's connection to Medicare and Medicaid. The section discusses Medicaid eligibility pathways, how only individuals qualifying for Medicaid on the basis of disability are counted as Medicaid enrollees with disabilities, and how individuals with disabling conditions not qualifying on the basis of disability, such as certain children with special health care needs may qualify for Medicaid through other eligibility pathways, such as the poverty level pathway.

This section also provides data that shows diagnoses of individuals qualifying for SSI as well as other demographic information such as education, household structure, and family income to help provide a more comprehensive picture of this population.

Analysis done by the Urban Institute for MACPAC looked at the National Health Interview Survey and found that, with respect to health status, adult enrollees with disabilities are more likely than non-disabled adults to report poor and declining health, presence of chronic conditions and functional impairments, restrictions of activities of daily living, and greater use of or more frequent use of provider visits, emergency department visits in the past 12 months.

Medicaid children with disabilities are more likely than non-disabled children to report fair or poor health, impairments limiting ability to crawl, walk, run, presence of certain health conditions such as ADHD or asthma, autism, developmental delays, and then are also more likely to report four or more visits to a health care provider in the past 12 months.

When looking at Medicaid-only enrollees, we find there is a high illness burden. The Center for Health Care Strategies has found that within the highest-cost 1 percent of Medicaid-only beneficiaries, 87

percent have three or more chronic conditions, and 67 percent have five or more chronic conditions. So the illness burden with the Medicaid-only subgroup is quite high.

April will now walk us through the next section of the chapter that focuses on Medicaid service use and expenditures.

* MS. GRADY: Thanks, Christie. As you just mentioned, I'm going to talk about some of the key points in the service use and spending section of the chapter.

The first point is that Medicaid covers comprehensive benefits for persons with disabilities. Many of those benefits may be either limited or unavailable through other types of coverage, including Medicare and private insurance. Persons with disabilities account for a disproportionate share of Medicaid spending, and that's the overall population of persons with disabilities. But in addition to looking at that total group, as Christie mentioned, we're also focusing on folks who are Medicaid-only enrollees and drawing some comparisons to those who are also dually eligible for Medicare. And when we look at that, we see that most Medicaid spending on persons with disabilities is for Medicaid-only enrollees, not dual eligibles who are also covered by Medicare. And, again, we'll get into a little bit more about that later. Medicare is covering many of the acute-care costs for this population, and so we would expect there to be lower Medicaid spending in some respects for them.

We won't have a complete picture of spending on the dual eligibles until June. That includes both Medicaid and Medicare spending. So for now we're focusing on the Medicaid-only costs in this presentation.

The other point we want to make is that Medicaid-only and dual eligible enrollees have different spending patterns, and we'll talk a little bit more about that.

Medicaid does cover comprehensive benefits, as I mentioned, in addition to the routine services. Key benefits that may be limited or not covered under other types of insurance include a variety of

long-term services and supports, and we talk about these in the chapter. They include institutional services such as nursing facility services that are used on a long-term basis, not just for a short stay following a hospitalization but for a longer period of time.

Intermediate-care facilities for persons with developmental disabilities are also covered by Medicaid. That's a unique service for Medicaid. There are also certain mental health facility services that are provided by Medicaid that may not be covered by other types of insurance.

Another key benefit, series of benefits covered by Medicaid include home and community-based services, and these include things like home health care, personal care for people who require assistance in their homes, a variety of need, and a range of other supportive services -- rehabilitation, therapies, a variety of things that may be provided under home and community-based waivers. And as you probably know, home and community-based services are steadily growing as a share of all long-term services and supports provided by Medicaid. Over the years there has been a push to deinstitutionalize people and to avoid their entry into institutional settings such as nursing homes in general. Right now home and community-based services, most estimates are that it's just over 40 percent of Medicaid long-term services and supports at this point in time.

Before I go through the next few slides, I just want to point out that we're showing fiscal year 2008 data, but we recently received fiscal year 2009, and we'll be updating the analysis for our March report to reflect that new information.

After we talk about the benefits available to people with disabilities in the chapter, we go on to discuss their Medicaid spending, and what this slide does is present some context for persons with disabilities in the Medicaid population overall. What we're showing here is that all persons with disabilities account for about 15 percent of enrollees in the program, but they are 42 percent of costs, so they're disproportionately spending relative to their enrollment. These numbers include all enrollees, again, both

the Medicaid-only folks and those who are dually eligible for Medicare.

CHAIR ROWLAND: You mean those who are dually eligible on the basis of their disability for Medicare, not the elderly.

MS. GRADY: Correct. The 15 percent and the 42 percent, yes, are limited to people with disabilities, some of whom are dually eligible for Medicare. The aged folks over 65 who are dual eligibles are in the aged category on this slide. We're limiting the analysis to the under-65 population.

There are some children who show up in the disabled category, but many children who may have special health care needs or other disabilities are enrolled in Medicaid on the basis of their income rather than their disability, so they do not show up in the disability category.

What we're showing here is a deeper dive into the Medicaid population of folks with disabilities, and what we're showing here is that most of the enrollees with disabilities are Medicaid-only enrollees. They are not people who are dually enrolled in Medicare. So they are 62 percent of enrollees, and they are also the majority of Medicaid spending: 69 percent of Medicaid spending on the disabled is for Medicaid-only enrollees. But, again, as I mentioned, we're only looking at Medicaid costs here, so we would expect to see that the dual eligibles are a lesser share of spending because, again, Medicare is picking up a lot of their acute-care costs.

On this slide the first thing I want to focus on here is the second column, and this is showing Medicaid spending per enrollee for different eligibility groups. As you can see, the spending ranges from about $3,000 a year for a non-disabled child up to more than $17,000 for an enrollee with a disability.

The second thing I want to focus on here are the bottom two rows, and this is further breaking out the population of enrollees with disabilities into those who have Medicaid-only coverage and those who are dual eligibles. And as you can see, the spending for the Medicaid-only enrollees is higher. It's almost $20,000 per year. For the dual-eligible enrollees who also have Medicare coverage for a lot of their

acute-care expenses, their Medicaid spending is about $14,000 a year.

VICE CHAIR SUNDWALL: April, a question. Is there a figure of total spending for the dual eligibles, the Medicare and Medicaid?

MS. GRADY: That's a good question. We don't have that right now. We haven't done that analysis. We are currently linking the Medicare and Medicaid files, and that's something we'll be talking about in June. This analysis --

VICE CHAIR SUNDWALL: It can be anticipated it would be higher than the Medicaid-only because of Medicare payments?

MS. GRADY: That's a good question. I can tell you that the disabled dual eligibles have a higher illness burden as measured by the number of chronic conditions than Medicaid-only enrollees, so I would not be surprised to see that their total Medicare and Medicaid spend is higher. But we haven't done that analysis using comparable years.

Okay. Now, as you can see on the right side of the slide here, what we're showing is the percent of spending on these different groups that goes to long-term services and supports and the percent that's going to other acute non-long-term-care services. And for the disabled Medicaid-only population, about 26 percent of their spending is on long-term services and supports; about 74 percent is on acute and other services.

If you look at dual eligibles with disabilities, about 63 percent of their spending is on long-term services and supports; about 40 percent is on acute and other services. Again, this isn't surprising because Medicare is the program that's covering most of their acute-care needs. We would expect to see that Medicaid is covering a higher proportion of their long-term services and supports.

Another issue that we cover in this chapter is that the use of long-term services and supports varies between Medicaid-only enrollees and those who are dual eligibles. And what we find is that enrollees with

disabilities who are Medicaid-only are less likely to be using institutional long-term services and supports. They're also less likely to be using HCBS waiver services, which require an institutional level of care. And as we noted earlier, this is due in part to the fact that the Medicaid-only enrollees report better health status than the dual-eligible enrollees, so we would expect them to be using less institutional care, less waiver care that requires an institutional level of care.

All right. That concludes the discussion of the service use and spending section, and Jen is going to talk about the quality section now.

* MS. TRACEY: Thanks, April.

So based on feedback that we received from all of you in our September and November meetings, I wanted to highlight some of the key points on quality measures for persons with disabilities in our draft March 2012 report. As we've just discussed, Medicaid enrollees with disabilities differ from other Medicaid enrollees in regards to their overall health status, the mix of services that they use, and program expenditures.

Currently we know very little about whether existing quality measures, which mainly target healthier populations, are sufficient for measuring the quality of care for more complex populations. We also know little about the quality of care Medicaid enrollees with disabilities receive beyond standard quality measures currently used for all Medicaid populations. These traditional measures have focused more on the utilization of services and include measures such as the number of hospitalizations, prescriptions filled, hospital readmissions, and ER visits. However, these overall measures do not capture the aspects of care unique to individuals with disabilities.

Given the high cost and multiple complex high needs of this population, as well as the array of services and delivery systems across states, it is important to gain a better understanding of the quality of care these individuals are receiving. This becomes increasingly more important as states are moving

towards transitioning these enrollees into managed care. Ultimately, however, whatever the delivery system, it's very important to understand more about the care these individuals are receiving and specifically ensuring that they're receiving the most appropriate care possible, understanding what the federal government and states are paying for in the way of services, and advancing value-based purchasing efforts.

MACPAC recently conducted an assessment to examine quality measures that are used and could be used to monitor the quality of care for persons with disabilities. We examined quality measures found in the literature, in publications by research organizations and quality measurement entities. We also looked at measures used by state and federal agencies and those found in state plan amendments, proposals, and state quality reports. We also discussed measures during interviews with select state officials and also national quality experts.

Our initial review, which is summarized in several of the draft chapter appendices, indicated that overall quality activities may not reflect the breadth of health care needs of Medicaid enrollees with disabilities and that relatively few measures align with individual specific health care conditions. Many measures that apply to the general population can also apply to these individuals, but more targeted measures may be necessary to address the special health care needs of this population.

We also found that most measures focused on managed care arrangements as opposed to non-managed care arrangements, and as we've discussed before in previous meetings, this may be attributed to the fact that federal regulations detail a number of quality requirements that states must conduct if they use managed care as the delivery system for Medicaid enrollees; whereas, these similar requirements do not exist for states that use fee-for-service or primary care case management arrangements.

So in the absence of quality measures, tailored to meet the unique needs of enrollees with disabilities, states and providers may adapt quality measures from a number of organizations such as the National Committee for Quality Assurance and the National Quality Forum to assess care for these individuals. Or

states may opt to create their own unique quality initiatives and tools.

Several states currently are undertaking quality measurement efforts specific to these individuals that include the creation of dashboards, multidisciplinary work groups, and comprehensive environmental scans which aim to combine the input and monitoring efforts of multiple stakeholders at the state level, and we have also outlined some of these efforts in the chapter appendices as well.

Many states have also attempted to fill measurement gaps at the national level by creating unique state quality measures. MACPAC conducted a separate analysis to identify unique quality measures developed and used by states that may be relevant to Medicaid enrollees with disabilities and also dual eligibles. Our analysis identified 66 state-specific quality measures across 16 different states, and these measures were used by at least one of the 16 states that we identified and are not existing HEDIS measurements. These measures addressed areas such as hospitalizations and ER visits, mental health and substance abuse, chronic care, access and costs, and care coordination.

So we look forward to receiving your comments on our draft section as well as the various annexes at the end of the chapter, and I just want to quickly point out that several of these annexes summarize findings from our initial quality assessment and also highlight the diversity of the quality organizations and measures that are currently available to states and providers.

Thank you. At this time I'll turn it back to Christie.

* MS. PETERS: Almost done.

The last section of the chapter addresses key issues for Medicaid enrollees with disabilities. The section identifies a list of key policy issues to be considered by federal and state policymakers providing care for persons with disabilities. We are looking for Commissioners' input as to whether this captures all the policy issues you would like to highlight at the end of this chapter.

Real quickly, as we've mentioned before, the per enrollee spending on the 5.6 million persons with

disabilities with Medicaid-only coverage is higher than all other Medicaid eligibility groups, enrollee groups. Their benefit package, persons with disabilities use a different mix of medical behavioral health and long-term services and support services than other Medicaid enrollees. Access to specialty care is important to meet the complex needs of enrollees with disabilities. As Jen just said, little is known about quality measures specifically for persons with disabilities. This is a high-need, high-cost population where care management and coordination of acute care, medical services, behavioral health, long-term services and supports, and support services would aid in the delivery of quality care. Perceived administrative burdens particularly around waiver application and renewal, however, may limit states' success in doing this. The role of Medicaid, Medicaid coverage of support services has broadened over the years, and then also there is limited information that is widely available in the best practices resulting from program evaluations of state approaches. In addition, there is limited independently secured evidence available on the impact of state approaches for individuals with disabilities on access, cost, and quality of care.

So these key issues identified in this last section of the chapter along with the following guiding principles, which are improved quality and appropriate access for Medicaid enrollees, minimize administrative burdens of operating the program and enhance program accountability, ensure that evidence-based program data and information are widely available and disseminated to appropriately implement and evaluate the effectiveness of the program. The combination of these key issues and these guiding principles were used to develop two proposed recommendations, and the proposed recommendations are:

The first recommendation, the Secretary should devise and disseminate strong evidence-based solutions for Medicaid beneficiaries with disabilities.

The second recommendation is: The Secretary should develop a core set of quality measures that can be used by states to measure the quality of care provided to persons with disabilities and to achieve

efficiencies in fee-for-service and managed care.

We look forward to your feedback on the draft chapter and on these proposed recommendations. Thank you.

COMMISSIONER RILEY: Well, thank you for all this work. It's terrific, and we've all plowed through all 55 pages several times, so we should get the quiz to see if we've learned it all. But I think what strikes me is there's been so much attention to the dual eligibles, and I want to say sort of, "Get over it," because certainly that's a critically important group of people, but when you think from a Medicaid lens, as MACPAC does and as Medicaid agencies do, it's so frustrating, even with all the enormous and wonderful work that CMS is now engaged in on duals, absolutely critical, great stuff, but, nonetheless, where you really have levers to make change and to do something about this incredibly costly group is in the Medicaid-only group.

So I think the first headline for our work is to rewrite -- first of all, the Venn diagram totally confuses me and I think understates our message. But Chart 10 I think states it, but it needs to be rewritten. We've fallen into the same dual eligible thing, and they're a minority here. They're not the -- you know, they're the subgroup.

I would rewrite the headline that most Medicaid enrollees with disabilities are eligible only for Medicaid, and that seems to me to be the focus of our work, the headline of our work, the new findings of our work. When you see those numbers -- I'd flip the chart. When you see those numbers of Medicaid-only enrollees and spending, the 62 percent and 69 percent, that's significant from a Medicaid perspective about where we as MACPAC and state agencies can do something about this.

The second thing that struck me in the discussion of service use -- and, again, I think we're forging new ground here -- is the one place where there's significant spending on this population is on targeted case management, and yet, again -- so we sort of have to work through our biases. We have been struggling for

so long about dual eligibles. We have to refocus on the fact that the majority of people and the majority of spending are not dual eligibles but Medicaid-only.

Similarly, we assume that we need better coordination and care management, maybe, and probably we do, yet already 11 percent of the funding -- the highest amount of funding is on targeted case management. What's that about?

So it leads me to my sort of third headline, which is that we really have very little -- and the quality piece I think is terribly important. We have very little evidence of what works best to maintain and improve functioning for these populations and to sustain quality of life. And I think that has to be our focus. I worry if we -- when we think about quality, we need to think broadly. Are we looking at quality of the right kind of services? Are the service mixes these populations are getting the right services? I'd hate to spend an enormous amount of time looking at quality metrics for the wrong services for these populations.

But I think those headlines make this a very important -- this is important work, and work that Medicaid agencies can really find -- and CMS as well can really find actionable activities to engage in more meaningful ways to serve these very vulnerable populations. But thank you for your great work.

CHAIR ROWLAND: Okay, Burt.

COMMISSIONER EDELSTEIN: I'd like to second Trish's comments about the comprehensiveness and the value of this contribution. It's really quite terrific. Whether you're looking at the needs section, the benefits and coverage section, or the quality section, especially when words like comprehensiveness are addressed, it's immediately obvious that oral health services are simply neglected from any consideration in this chapter.

And yet, disabled populations, whether pediatric or adult, recognize lack of high needs and lack of services as significant problems, and something that I think would add significantly to this chapter.

Additionally, the fact that Medicaid does not require dental services at all for adults, and that the majority of states provide minimal or no dental services, many not even providing emergency relief of pain and infection, is something that needs to be highlighted, especially for the disabled population, many of whom have significant limited communication capacities.

And so, being stuck with acute oral problems and not being able to express those puts the disabled population in a particularly terrible bind. So I think that the Commission needs, at some point, to wrestle with the question about whether we will continue to accept the notion that the mouth is segregated in Medicaid policy from the rest of the body, and whether people who have infections, trauma, acute painful conditions in the mouth should not have coverage simply because historically Medicaid has not covered adult dental benefits.

CHAIR ROWLAND: It's a very good point because coordination of care, if the care isn't being provided, you can't coordinate it. And I think dental really should be included in our chapter.

COMMISSIONER EDELSTEIN: And I want to point out that it fits across the chapter. It fits in the needs section, it fits in the benefits section, and it fits in the quality section. And because the dental system is different than the medical care delivery system, you have some of those same issues about crossing over between medical and dental -- I'm sorry -- between medical and mental as well.

And so, you have just a complexity of care coordination issues. And with the growing recognition, particularly in adulthood, that advanced periodontal disease is related to so many exacerbations of underlying medical conditions, sometimes this neglect of the mouth simply puts the disabled, in particular, but all adults who have such needs in a sort of double jeopardy.

CHAIR ROWLAND: Next David and then Donna.

VICE CHAIR SUNDWALL: Thanks. This was good to have this overview. We wrestled this morning, the Commission, with some of these recommendations which Christy finished with, and I have to

admit that after hearing the presentation and thinking about this a bit more, we've got to revisit number one. It's too weak. We just can't say the Secretary has to come up with solutions.

I think our previous efforts, and we're not going to wordsmith right now, we've done enough of that, but I really do think this needs a little more --

CHAIR ROWLAND: Might be nice to have solutions to what?

VICE CHAIR SUNDWALL: Yeah, right. Solutions. Solutions are really wonderful. So I will just say that this is one Commissioner that wants us to revisit Recommendation One, and I'm sorry, Patty, I hate to wordsmith anymore, but we have to beef that up a bit.

And, Trish, I know your point is well-taken about the focus really is on the Medicaid-eligible disabled. However, I don't want us to -- I don't want to convey the impression that the duals are therefore not important or don't merit our attention. And like you said, CMS is doing some good work and it's going on around the nation and Congress is very interested in the dual eligibles for good reason.

But I don't think the public has been aware of the scope or the cost of these Medicaid-only disabled. So this will be a nice contribution of our work to date. So anyhow, we'll just have to work together on resolution of our first recommendation.

CHAIR ROWLAND: Andy?

COMMISSIONER COHEN: I thought I got skipped and that was okay. I was going to be patient. I have a comment and then also a question, so first of all, great job and I do think that the findings here are really interesting. Obviously a lot of great work on dual eligibles being done to do the really hard work of figuring out ways to align two different programs and all of the requirements and sort of like arrangements around them with dual eligibles.

But we now know that the highest cost group of Medicaid enrollees actually are all Medicaid and are already sort of fully within the control of different Medicaid programs to devise and develop solutions. So

I think that is a really important sort of point to direct our all-policy makers kind of priorities.

So I did -- one thing I really loved about the chapter, and I think is often missing in discussions, you know, sort of data heavy discussions about spending and use was the description of the different examples of disabled enrollees, the kinds of conditions that they have. So some discussion about conditions and some discussion about kind of like what their constellation of conditions might be.

I did notice, I don't think there was an example of a person with a behavioral, like a mental illness. I think that's really missing. And I wanted to say that in general, I feel like there's not quite enough attention to the specific issue of substance abuse and mental illness in the chapter about the disabled.

I do think there are, obviously the disabled are an incredibly diverse group and many different underlying conditions that relate to disability, but there are many commonalities about disabilities that derive from mental illness and other behavioral health issues, and I think that it's important to put some focus really on that issue in general.

I know that that issue gets an awful lot of attention, so I think it was actually great to show the wide diversity of what are disabilities. But when it comes to really focus policy-making or program development, I think we need to dig a little bit deeper and look at that.

I also had a question. At the beginning of the chapter, you talk about not only are the disabled a high spending group, but the growth, they represent a lot of the growth in Medicaid spending, and obviously growth is one of the most important things we need to talk about.

It says that that's not only spending per enrollee, but also population growth in the disabled, disproportionate growth in the disabled category. And I wanted to ask whether we know or can know whether that represents sort of a change in the distribution of the Medicaid population generally so that people who previously might have been Medicaid-eligible but wouldn't have been determined disabled are now more frequently entering the disabled category.

So in other words, their spending and their characteristics are now being sort of captured in the disabled group, but they might have been Medicaid-covered in the past, because if that is the case, that might change some of our kind of thinking about -- in other words, if they're just changing categories, that might change some of our thinking about their driving the growth. So just wanted to raise that question.

CHAIR ROWLAND: Sara, then Don, and then Patty.

COMMISSIONER ROSENBLUM: Great job. I think this is really maybe our biggest contribution to date as a Commission because this issue has been so overlooked. Several points. First of all, just to, I think, come at sort of the same issue that Andy did, a little bit of a different take, you do a good job, but I think we need to do a better job of expressing to readers the great number of children and adults with functional limitations who fall outside the definition of disability because the definition is so restrictive.

I think people need to understand that the definition was developed, of course, as an income replacement program in 1972 for people who could no longer work. But as a nation, we've come a far, far way in conceptualizing disability for purposes of social services and supports.

So the definition, obviously, is completely inapplicable to children, for example, which is why the Supreme Court in Zebley came up with a different way of coming at the problem. And the definition, of course, predates by almost 30 years -- 20 years -- the articulation of disability that we now, as a modern society, have under the Americans with Disabilities Act.

I think we really need to drive this point home, that the definition itself is extremely restrictive, and it has several spillover consequences, including not assuring that Medicaid is open, particularly to adults who need it right now. Children, of course, have the benefit at the moment of being able to come in potentially as poverty-level children, but adults do not have that kind of a catch-all pathway. They may beginning in 2014.

A second point is that Congress has recognized this problem. Again, we mention it in the report,

but I don't think we drive the point home enough. And most prominently with the Ticket to Work Act in which Congress stepped in to attempt to rectify what has been this paradox of individuals who attempt to re-enter society in the sense of working and doing all the things that the income replacement program of SSDI doesn't allow or SSI definition, but then, of course, jeopardize their insurance coverage.

So I think that that point, again, needs to be made about the need for a more -- concerns about the narrowness of the definition.

A third point is that I don't think, and we mention it in passing, but I don't think people appreciate the significance of it, that there are 11 states out there that potentially still use a definition of disability that is, in fact, perhaps even narrower than the 1972 definition that was added into law.

I don't know at this point, among the 11 209(b) states -- it's the kind I used to know when I was in legal services, I don't anymore -- what precisely the current operating definition of disability is in those states. I think we should show it on a table and I think we should at least try and address the question of how well children and adults with disabilities in those states might do under the remaining pathways that are available to them, because this is the -- whatever is a problem in the non-209(b) states is potentially a bigger problem in 209(b) states that stay with the highly restrictive definition, and other than poverty-level children, really don't have any way to get coverage.

Two more points. I think the medically-needed description in the chapter is incorrect. You cannot be a medically-needy adult unless but for your income and assets you meet the underlying test of eligibility.

So there's an allusion to the medically-needy program that's worded in such a way, as is suggested, it's an additional pathway into the program, even for people who don't meet the disability definition. You have to meet the disability definition. You may be over income and resources you can spend down. I just think that needs a clean-up.

And my final point is –

CHAIR ROWLAND: I think there needs to be a clarification there. You can also qualify for the medically-needy program if you meet the parent category.

COMMISSIONER COHEN: One of the other categories, right, but you can't just be an adult --

CHAIR ROWLAND: You have to have your category--

COMMISSIONER COHEN: Yes.

CHAIR ROWLAND: -- for eligibility.

COMMISSIONER COHEN: Exactly. You'd have to be tied to an underlying eligibility category plus have excess income and assets. So an adult who just has some activity limitations but doesn't meet the full-blown definition of disability is not going to be able to come onto the program as medically-needy unless he or she is also a parent or, you know, an essential caretaker, somebody who falls into one of the other categories. So I just don't want to suggest that there's a pathway other than that pathway, those kinds of pathways.

The final point is that I think it's very important for us to -- I note to readers that it's not just that Medicaid covers classes of benefits that are not replicated in commercial insurance, but that even within covered classes, it covers benefits at a scope and depth that may be far beyond what a standard insurance policy would cover.

And so, Medicaid becomes extremely important, not just because it offers whole classes of services that aren't covered, but because it offers depth of coverage or a scope of coverage that doesn't really show up in a standard insurance plan. We're going to be worrying a lot as a nation about what's a standard insurance plan, and this point about Medicaid is probably going to be true even, you know, in 2014 and beyond.

COMMISSIONER CHECKETT: Well, the worst thing about, you know, as the discussion goes

on, all my fine points are being taken. But I will repeat again the excellent work done by the group, and I am so excited because I think we have really come up with some very important findings. So again, expressing my enthusiasm barely contained.

A couple of points. One, I wonder, Christie, could you pop the diagram back up if you can deftly maneuver? Because I really like the diagram. I have a couple questions about it. One would be, I know it's there, if we can show a version of the Venn diagram which is now -- all right.

Anyway, if it were up there, could we show a version of the Venn diagram that would maybe show the dollars? Is it percentage now? That's what I'm trying to recall. Or is it the dollars? Okay. It's the enrollment. So one thing to think about would be like another version of that that would show the dollars, just an idea, or a percentage of the dollars, just so that it's not just the enrollment.

So one idea on that. I need to really see it again to make sure. Yeah. So we're just really looking at the numbers of people, and so it would be interesting to me to be able to look at that in terms of dollars to like reinforce our points.

COMMISSIONER HOYT: Drawn to scale.

COMMISSIONER CHECKETT: And a little maybe drawn to scale so we know that Russia is actually bigger than the United States or something like that. But just a little side comment. Sorry. I'll contain myself.

And the other idea, I'm wondering if we want to just look at somehow shifting the obelisk so that we bring our Medicaid focus more in the middle of it somehow. I'm not an artist. I'm going to let you guys play with that. But I really like the slide. I like the write-up.

A couple of points I do want to just point out and one thing that Andy touched on, but I've been personally interested in this issue for a long time and it is compelling when you read through the draft, that for, I think, 50 percent of the expenditures are going for behavioral health services. That's what wrong

with a lot of these people and it is really important, so I want to make sure that message comes through.

And then because so many people, when they look at Medicaid and complain about the population and complain about the program, this use of the inappropriate use of emergency room departments comes up, and what I know from running Medicaid programs, running Medicaid managed care programs is that the population that is costing generally the most in emergency rooms is this population.

We might have a lot of moms there inappropriately, but the ones who are there over and over again costing a lot of money are the ones with the behavioral health and a physical health diagnosis.

I don't know that we can get into this in this chapter. That remains an issue that I still think we should look at some point. And so, thank you, and again, great work.

COMMISSIONER GABOW: I, too, have several comments. The first one, I think, is that I think it's worth pointing out that when we try to think about quality measures or appropriate care, we need a goal for what is the goal that we have for caring for people with disabilities? There would be a whole range of those. But if we don't know where we're heading, it's certainly easy to get to the wrong place.

So not that we can come up with a goal as a Commission, but I think pointing out that we don't know what that is is important.

Sort of to expand a little bit on Sara's point, I was surprised and interested in the comment that many of the children who are disabled are getting into the program on an income level, not on disabilities. And so, we are under-estimating dramatically both the scope and the cost of the program.

And so, some data about how many kids are in that bed and what is the level of their disability seems to me to be relevant to understanding needs and costs.

CHAIR ROWLAND: One way that you might look at that is to look at the very high cost. I think CMS has done it and Urban has done it, the very high cost population within Medicaid, and you see that there's a small share of children and a small share of parents that fall into that spending of over $20,000

a year.

But that might, at least, you can't link that to conditions because that's not there, but you could at least show what portion of the traditional moms and kids part of Medicaid also include some very high need, high cost patients.

COMMISSIONER GABOW: And I think just pointing out that we're under-estimating this, as big as it is, it's still an under-estimate is worthwhile.

The third point I want to make is about the medical and behavioral health issues. And as you know, one of my perseverations is the problem of separating, in many state programs, physical health from mental health. And we just did a cut of some of our data of our very highest tier of severity patients, and what was interesting -- well, there are a lot of things interesting about it, but one thing that was interesting is they really fell into two buckets.

One was a group that had primary severe mental illness that were being cared for in the mental health system, but they also had many coexisting physical health issues that were not being cared for because if you just give those patients a message, Why don't you go over to another place here to get your diabetes and your congestive heart failure, you know, taken care of, they never made it there because these two systems were just too complex.

The other group that was in that highest tier had severe medical problems, but they also had coexisting mental health issues, but because that funding stream and delivery arm was separate, they weren't getting the mental health care. So I think pointing out that this separation of the delivery system and the funding stream, while it's a problem for everybody, for these patients is extraordinarily problematic, and probably generates a lot of unnecessary cost because either their mental health situation is not being taken care of or their physical health situation is not being taken care of.

If I could just do two more things? The other thing that I found was startling in here was that

most children -- or that many children, it doesn't say most, lived in a household with at least one other individual who was reported to have a disability.

We don't explore the implication of that, but if that's the adult who's responsible for them, it seems like there are a lot of downstream issues that would emanate from that, and I've really never seen this discussed, about this clustering and what the implication of the clustering is for care.

But I think it's worth pointing out. It's also interesting about what is the etiology of this if they're clustered and does that deserve some attention?

My last comment is that I'm glad I didn't have to write this chapter. It is really complicated and I got lost sometimes in it saying, Oh, how did this -- I thought this was different on two pages before than it was here. And I'm wondering if something like a flow diagram would be useful, and maybe it wouldn't because maybe it's not possible to construct.

But, you know, you're disabled and you're poor and how do you get into the various programs? Because we list all these different routes. But if you're just trying to read it, it's really hard. And maybe it's so complex that the lines are crossing and going backwards. But that's probably useful, too, to figure out some of this because it's hard to sort of understand the sequencing.

CHAIR ROWLAND: Judy?

COMMISSIONER MOORE: I join everyone else in saying a monumental piece of work and I do hope that people understand and pay attention to our great interest in this. And it's been mentioned here before, but I want to emphasize again that I think the chapter needs to be as clear as it possibly can about the heterogeneity of this disabled, Medicaid-only disabled population, not just with regard to the behavioral health, overlaps and the folks with mental health and substance abuse problems, but the vast differences between those with physical disabilities, those with developmental disabilities, those with a whole variety of intermingled conditions.

And it relates to the needs of those folks, to the benefits that they get, to the goals and outcomes that we have for them, and even to the quality measures that we design. And it just cannot be one size fits all because it won't work. So I want to just make sure that we get that message as part of those headlines that we're trying to get out there about the very high cost and high needs of this particular population.

It is not and would not be served by the rest of the health care delivery system in private insurance or other ways.

COMMISSIONER CHAMBERS: I know I'm not supposed to use the M word or the D word, but I can't help myself so I'll go ahead and do it anyway. M word, managed care. I know early on, it was -- earlier versions of the report, it was to discuss the delivery system services for this population, and I think it was the smart move because Trish really made impassioned pleas that we really need to understand who this population was if we're to focus on how you deliver those services, particularly as the wide array of acute, long-term care, social services. Patty just brought up behavioral health.

All those things of understanding the population are really key, but really look forward to the future discussion of the intersection between managed care and delivery of services, particularly as the states move faster and faster to enroll these populations and to assist them, that while I'm obviously a very huge supporter of, but at the same time as we need to understand more.

As before, there was this wholesale turning of populations over into a system where many states, I can say for my own state of California, it's usually with a price tag attached to it. It's an easy way to find some savings very, very quickly, but it may not be the best system of care for very, very vulnerable populations.

And then the D word, obviously the dual eligibles which is going to be a focus in the June report. But as we try to draw very bright lines between dual eligibles, disabled dual eligibles in the Medicaid-only, is to make sure we don't miss that. At the end of the day is they are populations that are very vulnerable.

They have different funding streams for financing their services, but when you focus on the individual is they're very similar in their needs, utilization of services, and I just look forward to us as we bring that report forward in June, is to be able to make it clear as while we're focusing now on Medicaid only, we are a Medicaid Commission, is that this is a population that we do need to make sure as we're saying it, very similar populations. Thanks.

CHAIR ROWLAND: I also know we're trying to draw a bright line between the dual eligible disability population and the Medicaid-only disability population, but I think we should be clear that within the Medicaid-only population are people in the two-year waiting period waiting to become Medicare/Medicaid dual eligibles. So can we get any measure of, you know, what that number might be in any given year?

But I think it's just important to remind Congress that that waiting period has something to do with some of the people who are in this population. Denise?

COMMISSIONER HENNING: When I was reading this chapter, I thought it was interesting to note that we as a country and as a health care system have finally figured out that mental health are belongs in with health care, but still, to Burt's point, dental health care is not considered an essential benefit, according to Medicaid, at least not for adults.

As more and more studies come out with its effect on heart disease, its effect on immune system diseases, it's effect on pre-term delivery, I just don't understand it. You know, I mean the mouth is right there right next to the brain. You get an abscess in your tooth, and you could be dead. I mean, there are people that die from dental disease, and yet, you know, we don't consider it important enough to cover. And I think that that's one thing that as a Commission, pointing out that over and over and over again, if that's what it takes, I think we need to do it.

COMMISSIONER MARTINEZ ROGERS: A quick statement, and that is that -- I can't

remember who -- oh, I think it was -- I can't remember who it was that brought up the issue of mental health and, you know, they go to one place and they go to another place. I think that one of the things that we don't state in this chapter is the need for people who have disabilities to have specialists take care of them. For instance, the schizophrenic woman who becomes pregnant and needs specialty care, and how do they interact and how do they talk to each other in order to provide the best care possible for this individual?

The other is that just something kind of technical, and that is, I would like to see in the chapter the physical characteristics of the definition of disability further up front, mentioned a little bit further up rather than in the middle of the chapter, because it's kind of like you're going back and forth, and we're really trying to define it. As Sara was saying, it really needs to be spelled out, and I think that's something that would help in this chapter.

Thank you. You have done wonderful work. I really, really appreciate it.

COMMISSIONER GABOW: Do we know anything about the ethnic disparity among this population compared to the -- is it different than the Medicaid population as a whole? And does that have implications for us about the delivery model? I've never seen anything, but I certainly don't know this area very well.

CHAIR ROWLAND: So I think that -- Robin, sorry.

COMMISSIONER SMITH: Well, I just want to say this is such a vast amount of money being spent on this population. I think it's really like a mine field we can just go in and really make a difference with some efficient services. And I think it was Trish who said if we can get the right services, not duplicate services, I think we're going to see a cost savings and quality of care increase. This is my thing, and I'm really pleased and very excited. I'm like Donna. I don't look it over here, but I'm very excited about this chapter going forward.

[Laughter.]

CHAIR ROWLAND: You know, I found it a little difficult to go through the first part. I know we've struggled with how to structure this, but to go through kind of who they were and then later get to their service use and their cost, because part of their service use and their cost reflects who they are, and looking at page 13 on the SSI recipients by qualifying diagnosis, you almost immediately wanted to jump into so what do we spend on people with different kinds of conditions and how does that vary. And I don't know whether there could be some more integration there that would help people to better understand why they're such high-cost populations. And I think that's a little bit disjointed in the way it has been written here, understanding multiple authors and not to say that what's here isn't rich, but I think it goes to Patty's point of you read something a few pages later, and you say, "Oh, well, how does that relate to what I read before?"

Other comments? We can go back to David's comment. I think he's perfectly correct in saying that telling the Secretary to devise and disseminate strong evidence-based solutions for these beneficiaries without saying what kind of solutions we're even looking for may mean that that recommendation certainly needs much more work before it rests as one we should be recommending and voting on.

The second one on the core set of quality measures, comments on either of those?

COMMISSIONER ROSENBAUM: I think David is absolutely correct. I think that in our effort to sort of get a manageable recommendation, we ended up throwing out so much that now we sort of have no recommendation.

But one of the things that I think we should focus on on the nature of the solutions we want to see is not just solutions to ways in which one delivers health care to this population, but solutions to what is in my experience the biggest challenge of all, which is integrating their health care with the array of health-related and social services that are simultaneously being provided to many people who fall into this

population, particularly in the case of children, because, of course, there's a complete -- there's got to be complete integration with educational programs, often with child welfare programs. And so I think when we rework the solutions recommendation, we ought to be saying we want you to come up with solutions both to their immediate health care needs and that integrate these services with the array of services these populations get.

CHAIR ROWLAND: Do we want to say something like the Secretary should devise and disseminate strong evidence-based approaches to improve the coordination and quality of care for persons with disabilities, or, you know, start thinking in that --

COMMISSIONER ROSENBAUM: Yeah, I think both the quality of the clinical services that Medicaid pays for, the clinical and support services that Medicaid finances directly, as well as the integration of those services with the array of other health, educational, social services that this -- huh?

PARTICIPANT: Oral health.

COMMISSIONER ROSENBAUM: Health. You see, when I say "health," as Burt knows, I don't exclude the mouth, so yes, absolutely.

VICE CHAIR SUNDWALL: Sara, I don't want to lose -- excuse me. I'm sorry, Andy. I don't want to lose what you said this morning. I thought it was profound. Why we do this? It's our collective conscience. It's what we as a society feel we need to do. And I think we don't talk about that. It's costly, it's difficult. I'm still a clinician. I see some of these patients, and it's just damn hard. So we need to somehow get -- I hope our Commission will say something like you said this morning.

CHAIR ROWLAND: Okay.

COMMISSIONER COHEN: If appropriate to move to the second recommendation -- do you want to talk about 1? Go ahead.

COMMISSIONER RILEY: On 1, I don't want us to lose the what, really to find what the

evidence is about what works. This is a population that has been more litigious and more driven by consent decrees and court orders that may or may not be evidence based and may or may not be producing the right kinds of services to really help folks. So before we get into quality measures, I think we've got to be very explicit in that first one that we really need some information to know, of all these vast arrays of services that cut across education and behavioral health, what works? And if we don't know, how will we find out?

COMMISSIONER COHEN: So on the second recommendation, I just wonder about quality measures. I wonder if we should be so tied to the Secretary developing a core set of quality measures for people with disabilities or recognizing the heterogeneity of the population, whether or not we should at least leave open the possibility that there might be defined core sets for different subgroups.

COMMISSIONER CHECKETT: I was sorry in the drafting of our first recommendation that we -- I know we struggled with the language around prioritizing and emphasizing, or rapid learning, whatever. I really still like the idea that one of the things we want the Secretary to do is to develop models of care that have outcomes and that work and that we can streamline and let states use those without going through the gyrations they continue to this day to go through. So I'd like to see that incorporated in some way into one of our final recommendations.

COMMISSIONER MOORE: And on that same stream of thought, it seems like our recommendations as a matter of drafting ought to be able to stand alone and be understood, and we don't want to use particular kinds of approaches, but I think this recommendation needs to highlight the importance that we attach to more attention to Medicaid for Medicaid-only people with disabilities, and I don't think we've captured that yet. So I'm not sure we -- we always dump these things back on the staff, and then they come forward with wonderful new words for us, but I'm suggesting we should dump that one back there, too. But we should have that kind of a -- it should be a stand-alone statement or a statement

that is more self-explanatory and straightforward than I think what we've come up with at this point.

VICE CHAIR SUNDWALL: [off microphone] But this is narrow for Medicaid disability.

COMMISSIONER MOORE: Yes, yes, and I don't have any problem with the narrowness of Medicaid for people with disabilities, but I want that to be clear other than just in the title and then below that. I mean, I think those words needs to be in there, too.

CHAIR ROWLAND: Okay. I think this has been useful and helpful, I hope. Certainly it has been to us on the Commission. I don't know if the staff would agree, but we have, I think, a really strong content here, a really wonderfully done chapter that can only get better. And, hopefully, we've helped give you some guidance to give us the ability to really put this chapter, which we really do think is the centerpiece of our work, out in the March report.

And with that, we'll turn from this issue, which is disabilities, to the access-to-care issues that are another part of our plan for the March report.

Chapter 2, Chris Peterson.

ACCESS TO CARE FOR CHILDREN ENROLLED IN MEDICAID AND CHIP

* MR. PETERSON: Thank you very much, and thank you all, Commissioners, for your comments on the draft chapter. I found them very helpful, and even when you didn't have comments that were edits per se but were just kind of observations of, "Oh, here's what I think might be going on," or "My experience kind of suggests something along these lines." I found that very helpful, so I appreciate that as well.

CHAIR ROWLAND: Let me just clarify for the public. We've been reviewing chapters via e-mail and conference calls and comments back to the staff so that we can be at a better place as we move forward here. So this is not the first time the staff has had to revise things.

MR. PETERSON: And so this is on the chapter on access to care for children enrolled in Medicaid and CHIP. The way that I'm going to go through this presentation on children's access is just to briefly set up a bit of context for the chapter; to discuss the chapter findings, which were structured after the access framework that the Commission put in its March 2011 report, so that's looking at enrollees and their unique characteristics, provider availability, and utilization of health care services. And I found it quite useful to be able to use that structure for the first after the chapter. And then we'll talk some about the data sources and methods, noting that those data sources and methods will appear as an annex to the chapter, but that there will be supporting online materials that will be released simultaneously with the report that will provide much greater detail in two parts: number one is the contract report that was authored by Jenny Kenney and Christine Coyer or the Urban Institute. They produced these findings, and then a technical appendix to that contract report providing even more detail. And then we'll wrap up by a discussion of the final section of the chapter about looking forward and our next steps here.

So MACPAC, as you well know, is statutorily required to monitor access for enrollees in Medicaid and CHIP, and in March 2011, as I mentioned, MACPAC presented its access framework. And children comprise about half of Medicaid enrollees and the vast majority of CHIP enrollees, and so that was the motivation for, one of the motivations for having an access chapter on kids to go first as we produce and present our first findings of numbers on access.

So the chapter findings, the key take-home points are that for almost every measure of access to health care, children enrolled in Medicaid or CHIP have better access to care than uninsured children; and then, secondarily, across most but not all measures, children with Medicaid or CHIP have access to health care that is comparable to children with employer-sponsored insurance, ESI.

As I mentioned, the chapter presentation of findings does follow the three elements of the Commission's access framework, so beginning with enrollees and their unique characteristics, and the key

point of that, of course, is that Medicaid CHIP children look different. They are different in their profile from children with ESI or uninsured children. And so the results that we present are trying to account for that.

Then two is provider availability, so when we compare children who have Medicaid and CHIP to those with ESI or the uninsured, what percentage have a usual source of care? What does that source of care look like? Are children able to access care from that source after hours, for example? So those are the provider availability questions.

And then the final element is the utilization of health care services, so that is: Did the child have a well-child visit during those year? Those kinds of things.

So to preview some of the findings that we present in the draft chapter is on the left-hand side you see that Medicaid and CHIP children, approximately 82 percent has a well-child visit during the year, and once controlling for factors so that we're looking at similarly situated children with ESI, it was statistically significant, even a greater rate of well-child visits, and, of course, the stark difference, so it's often been the case that folks have commented, "Well, yes, those are statistically different, but maybe not substantially different." But when you look at the uninsured, that's where you see substantial differences. And a similar kind of finding for any office visit.

Actually, I'm going to black this out quick because I do want to talk about -- I think this particular slide needs a little more context. So one of the findings -- and it's in Figure 5 in your draft chapter for the Commissioners -- is when you look at whether children had any delayed care, uninsured children have much higher rates of having any delayed care, for whatever the reason, and Medicaid CHIP kids and similarly situated ESI children were kind of in the same ballpark.

When looking at delayed medical care because of costs, not surprisingly, uninsured children, that tends to be their number one reason far and away, and Medicaid CHIP children have much lower rates of

delayed medical care because of cost. Then there are other reasons that individuals are asked to provide, and so that's -- when you see this slide, okay, so the uninsured kids, we know that primarily they're delaying medical care because of cost, but is it also the case that they delay medical care because they could not go when the place of care was open? And this is one of those cases where, when you look at children with Medicaid and CHIP versus ESI, there is a significant difference. Again, one could argue, well, this is not a large difference, nevertheless it is statistically significant.

And then a similar finding, delayed medical care because the wait was too long. Children on Medicaid and CHIP have a slightly higher rate, have a statistically significant higher rate compared to children with ESI.

COMMISSIONER CHECKETT: [off microphone] Wait for what?

MR. PETERSON: The wait to get into the office to see the provider. Right, so this is --

COMMISSIONER CHECKETT: [off microphone].

MR. PETERSON: Okay. We can -- yes.

COMMISSIONER HENNING: Would we please, please say that rather than "wait to see the doctor"? Because it may not be the doctor they're waiting for. It may be a nurse practitioner, a physician's assistant, a certified nurse midwife, you know.

MR. PETERSON: Right. That's true.

COMMISSIONER SMITH: A quick question. Do we know how long the wait was?

MR. PETERSON: No.

COMMISSIONER SMITH: Was there a criteria for what was too long a wait?

MR. PETERSON: No, this is just based on their perception.

COMMISSIONER SMITH: Okay. I got you.

MR. PETERSON: Honestly that's a good point for me to bring up, the fact that, again, this is

based on people's perception. So to the extent that, let's say, Medicaid and CHIP enrollees have a different perception of what is too long versus, you know, parents with ESI, for example, then that may also drive some of these differences.

COMMISSIONER ROSENBAUM: I think this is a case where we just need better titling, because while the left-hand side is not so impressive, you know, the right-hand side tells us something very important, which is that Medicaid is associated with much longer delays or more people running into delays in getting an appointment at all, which is consistent with people's sort of anecdotal experiences with the program, that, you know, a rheumatologist in town who sees children may have a relatively open scheduling policy for children with ESI but Medicaid is much more controlled, they'll only see so many. That's the issue, I think.

MR. PETERSON: Yeah, good point.

CHAIR ROWLAND: I would also just check the variable the way it was put together when they ran the data to see if they can find other things as well as time for an appointment because I thought that their definition of waiting too long was a little broader than just appointment times.

MR. PETERSON: Okay. We'll look that up.

COMMISSIONER CHAMBERS: Can you say why the uninsured had the least -- only 4 percent delayed care? Was it because they didn't pursue care?

MR. PETERSON: That was -- that's why I made that original point, that primarily the uninsured are delaying care because of cost. And then these are secondary and tertiary reasons.

COMMISSIONER CHAMBERS: Okay.

COMMISSIONER MARTINEZ ROGERS: Was that said or is that your opinion?

MR. PETERSON: Well, that was why -- you can see this in Figure 5 where that delayed medical care because of cost, that is the primary driver of why uninsured kids are delaying care.

COMMISSIONER ROSENBAUM: I think this is the problem with -- and I don't know what we do about it -- sort of not having the whole picture; that is, I would assume that cost is the factor, also means that you don't delay your care because you're waiting too long because you don't even try to get the appointment. I mean, you're not even looking for the appointment because you can't afford it for your child. And so somehow -- I don't know, because I'm so terrible with showing numbers, how we fix that kind of thing, but whether we have a long not explaining that probably the reason that this figure looks so peculiar is because there's a disincentive to even seek the appointment.

MR. PETERSON: Yeah, and we'll try to make that clear in the context of the fact that Figure 5 will come first and make that point first, and then we'll emphasize the fact that these are additional reasons.

CHAIR ROWLAND: One of the interesting things in the report is that Medicaid and ESI are very similar in terms of having a usual source of care, but the uninsured, of course, are much lower. But among those with the usual source of care, the Medicaid population is less likely to have night and weekend hours than the privately insured or the uninsured, which doesn't square quite with the emergency room use that we associate so much with the Medicaid population, so that would also be worth looking into.

MR. PETERSON: Okay.

CHAIR ROWLAND: It seems like maybe that's because their usual source of care doesn't have evening hours is why they're going to the emergency room more often.

MR. PETERSON: Right.

COMMISSIONER WALDREN: Well, I was going to say, I don't know if we can pull a lot of that type of results -- I mean interpretation out of these results, because it could be the fact that those that have ESI are more likely to have employers that are more open with regard to being able to take time off of work to go take your kid to the doctor, where if you're in a salary -- a lower-income position you don't have that. So I think there are multiple things, and I don't know how much we can kind of pull out of this other than

the attitudes of the people that responded to these.

One thing you may want to do, though, graphic-wise is if you did a stacked bar graph of all these; then you could show kind of the overall delay according to what the responses were and what percentage was kind of each of the others.

MR. PETERSON: Yeah, or even at least put Figure 5 and this one in the same set so it's clear.

COMMISSIONER EDELSTEIN: I'd like to just place a place holder for further discussion after we let Chris finish his presentation that something doesn't jibe here -- well, two things for me don't jibe. One is the delayed care and the inaccessible care at hours that these people need to seek care doesn't jibe with the suggestion that everything is rosy for them and the kids are doing just fine. The fact that primary care providers claim -- and, Diane, you just mentioned the lack of availability of specialty care doesn't jibe with the kids doing just fine. And I also am anxious for Chris to explain some of the methodology because Chris has mentioned repeatedly that these are similarly situated kids, but I'm not sure that such similarly situated kids are anything but fictitious. And Medicaid kids are not similarly situated, so I need to better understand why the methodology was used the way it was because it seems to downplay differences, inherently downplay differences between ESI and kids in Medicaid.

In short, the methodology suggests to me that it would inherently show ESI kids and Medicaid kids to tend to look very much alike. And, you know, in actual experience they don't, but in these reports they do.

MR. PETERSON: So let's go to the next slide because that's where we'll talk about -- and I can at least set up this discussion a little better. The sources of data are from two sources: the National Health Interview Survey, NHIS, and the Medical Expenditure Panel Survey, MEPS. And both of these are nationally representative surveys of the U.S. non-institutionalized population, and these are surveys administered by the federal government.

In terms of the methods, yes, you're correct, the way that we have done this is to compare children enrolled in Medicaid and CHIP to uninsured children and children with ESI and to use, as Diane likes to say, the standard research approach of using regressions to control for factors that may otherwise affect the outcomes.

So as I mentioned, the chapter presentation will have a summary, which you have a draft of in an annex. In addition -- and, Burt, I think you'll appreciate, now that you have it in hand, because you just got it as part of these materials -- there is the contract report that goes into more detail as well as the technical appendix. And so now let's back up and get to your question. So we're not picking out from the survey similarly situated kids; that is to say, we're not taking Medicaid CHIP kids and then we're trying to find one over here who happens to match that.

This standard approach is to use the regression equations and say let's look at all the characteristics by which these children differ and assess the extent to which each of these factors -- race, ethnicity, health status, Medicaid CHIP versus ESI -- have an independent effect. And so then what we are left with, once we have essentially held constant all those factors, we can see what that marginal effect of ESI versus uninsured is to Medicaid and CHIP.

COMMISSIONER EDELSTEIN: And that's exactly my point. In doing that regression and then discounting the weights for the factors that are recognized that make the kids different, we make the kids look the same; but the kids are not the same, and that's exactly my point, that the kids in Medicaid need to be recognized for being more minority, for being poor, for being in poorer health so that we don't adjust out and look only at the marginal difference but look at the total difference.

So I understand the statistical technique. I just don't understand why we would apply it.

MR. PETERSON: And I would say two things. One is that the findings -- if you didn't take the step of doing similarly situated, the take-home story is still largely the same -- not with specialty care, and

what we find with specialty care is that low-income children, regardless of their source of coverage, struggle with obtaining specialty care, and that is borne out by recent research. Every few years there's a group of researchers that has looked at specialty care for orthopedics, and they have found these differences with Medicaid and CHIP compared to private health insurance and how much harder it is. And their latest findings were: Guess what? It's hard for everybody now, for all kids.

And so I think that's one of the primary points, but we recognize our need to tease out a little bit more that nuance, because the take-home story is not that Medicaid CHIP children have all the specialty care that they need. That is not the take-home point. And so we want to just give a little bit more nuance to the chapter, and I think you'll appreciate what we do. So I'm on the same page with you in that regard.

CHAIR ROWLAND: Burt, you can easily compare a child under poverty on Medicaid to a child in an upper-income with private health insurance and see differences in how they access the health care system. And you can also look at a child who's very sick and look at their utilization rate versus a child who's healthy and not. So one of the standard things one tries to do to just see if there's a program deficiency is to look at comparing apples to apples instead of apples to oranges, and in this case what we're looking at here is the standard that is actually in the statute of comparable access to people in comparable conditions. So we're trying to at least control as we can in the research for income and for health status, although all of those are very crude cuts. And you're right, the Medicaid population is different. And that shows up in different ways, but otherwise, what you get is the Medicaid population, the kids are sicker and they use more care than upper-income kids, and it looks like they're overutilizing. And it would be great if we had some standard of care for everybody, but we don't.

COMMISSIONER EDELSTEIN: One of the things Chris said that I think is important for the chapter to report is that, even without adjusting, the kids do well in primary care. I think if that's the case,

that is a powerful message. That's an even more powerful message, and then -- looking at the marginal impact of the program itself. But even in trying to interpret the federal legislation, you have to be very careful. We saw that earlier in one of our very first meetings when Jenny presented some of the dental findings, because she there compared low-income kids with ESI with low-income kids in Medicaid, and without the then realization -- now it's well understood, certainly by Jenny and staff, and I think by the Commissioners -- that dental insurance has so much out-of-pocket costs associated with it that low-income people with ESI effectively are uninsured. And so what looked like an appropriate comparison to a methodologist was not an appropriate comparison to people in actual existence.

So I think we as Commissioners have to keep our eye on who these kids are and what their and their families' life experiences are.

COMMISSIONER MARTINEZ ROGERS: I just want to make a comment, and I'm looking at Figure 7 on page 10. I know that you used the flu as an example of how ESI Medicaid CHIP kids get the vaccine. I find that really interesting because in the Latino population we tend not to get the flu shot, whether you're a child or whether you're an adult. And it's so much so that -- I know I've given talks for CDC throughout the United States in particular areas where Latinos live about teaching the parents that you have to do this, you know, you need to do this, going into the churches and giving talks. So I kind of questioned that.

The other is that -- and I just heard this this morning. I don't have the resource that they used, but it was on CNN, so take it for whatever you want. But Mexican Americans' children tend to be the fattest, and so when I look at -- in comparison to other populations. So when I look at the going -- exceeds other children, of going to primary preventive care, use the clinics or get outpatient care, I'm wondering: Is it because they need the primary care and the prevention? I mean, are there other issues that come up with that? Because we are the fastest growing minority population. We're the most uninsured. We're the

poorest, most uneducated. Most of us that are uneducated are monolingual, and if we're going to the doctor that much that exceeds because we're probably on CHIP, why? I guess that doesn't jibe to me in some ways. I mean, I know that we may go, but are we going because we're unhealthy versus healthy? I guess that's what I'm saying.

MR. PETERSON: The results adjust for different health status, and I'd be interested to see on the flu shot in particular whether there's a higher level that is affected by being -- yeah, but even in these results, there may be a differential effect that we could actually look at and say, well, yeah, that is borne out. So then there's the other issue of, regardless of their race, ethnicity -- let me say it like this: Even if they're Hispanic, regardless of their coverage they may have lower rates of the flu shot.

COMMISSIONER GABOW: I have several comments. One is I think it's interesting that in light of our previous discussion that it also says in the family characteristics that these children, Medicaid and CHIP children are more likely to live with a family member with physical or mental limitations. So we may be teasing out indirectly a theme here about both etiology and a different delivery model that's going to be necessary if the family of these children have more issues than others, that it may be very important.

Another comment that I thought we just need to clarify is on page 6 about the clinics and health centers. I think the way it's worded it implies that Medicaid and CHIP children actually more likely get their care at a clinic or a health center, but actually the data looks like the majority actually get their care in a doctor's office or an HMO. And so, A, I think that's pretty interesting on a number of levels, but the way it's worded implies just the opposite.

MR. PETERSON: Right, because it was a comparison of kind of the relevant differences, but I hear your point that still the majority got their care from a health care provider's office.

COMMISSIONER GABOW: Because I think that has a different implication, so you should just be clear about that.

The other thing that I think is amazing that maybe needs a little more elucidation is that 25 percent, almost, of all kids have an ED visit in a year, of insured kids. So, you know, if you take all kids, you're going to get -- I find that pretty amazing. I guess if you go around this table, how many of you had your kids in the ED every year? Every year? I mean --

[Laughter.]

COMMISSIONER GABOW: I mean, I know they do things, you know, and if you have boys, you're probably more likely to be there. But it just -- that seems pretty amazing to me. I think it's worth a little bit more of...I also think we could have a conclusion to the chapter. It needs a conclusion.

COMMISSIONER CHECKETT: I'm sorry. This is a really small point, but I have got to make it. I'm looking at page 10, and if you could, Chris, get -- the NHIS defines a usual source of care as an HMO, and, you know, usually that's an insurance company, and I don't know any of them that have their own doctors' offices. I'm thinking this is like a Kaiser model, a Kaiser office, maybe, like a group health plan. But it would be worth checking out. Thank you.

CHAIR ROWLAND: We will check it out. You know, many of these definitions are in the contractor report, which is behind the chapter in your notebook and which will not be in our report to Congress but will be posted on the website. And that lists how each one of those variables was classified, so you can see what they actually put into it.

MR. PETERSON: And, yeah, that is a function of the question itself, and so Table 2 of the appendix, which is just before my presentation in your materials -- and I'm pointing you to this because I want to flag some correction I want you all to make in your materials, and that is, Tables 4, 6, and 8, the second to last column says "regression-adjusted ESI." That should be "uninsured," "regression-adjusted uninsured."

MR. PETERSON: Okay. So now let me proceed, if there are -- okay.

CHAIR ROWLAND: We've got Norma and Burt raising their hands here, Chris.

COMMISSIONER EDELSTEIN: Thank you. I was just wondering --

CHAIR ROWLAND: Go ahead, Burt.

COMMISSIONER EDELSTEIN: I was just wondering what the urban findings were on dental. I appreciate that they're not being reported in this one, but the NHIS and the MEPS findings on dental.

EXECUTIVE DIRECTOR ZAWISTOWICH: [Off microphone.] Burt, we will present those -- sorry. We will present those at a later time. I think our goal is to look at dental issues separately, take a deeper dive, and we will do that at a later point.

COMMISSIONER EDELSTEIN: I'm still hoping that at least some top-level reference to them will show up in this chapter when the chapter is finished, which would then lead to the more detailed picture.

COMMISSIONER ROGERS: Just a quick question, again. You know, on the uninsured, on page four, the health characteristics, where you talk about Medicaid-CHIP, are children more likely to have asthma than those that are uninsured or have insurance, I'm just kind of wondering how they came to that conclusion. How do they know if the uninsured don't visit the clinics until the very last minute, you know, because that has got to be saying that they don't have many. And asthma is -- and I keep going back to Latinos, but I am a Latina and asthma is one of our major problems.

MR. PETERSON: So your point is that because the definition in the survey says, "Has a health care provider ever told you you have asthma," and uninsured individuals aren't going to a provider, they are not being told they have asthma.

COMMISSIONER ROGERS: Right.

MR. PETERSON: Yes. So we've -- I know we had a note on that, and I don't know if it was in the chapter or maybe the contract report, but we can -- we'll make a note of that.

CHAIR ROWLAND: Andy, Donna -- Denise, then Andy.

COMMISSIONER COHEN: Great work. I think it's a -- yes? My turn? It wasn't? I'm sorry.

COMMISSIONER HENNING: No, you can go.

COMMISSIONER COHEN: I'm sorry. Great work. I just want to make what is maybe sort of an obvious comment, but I think in the chapter, in the intro and in the conclusion, I think we just want to be very clear about what this study is and what it does say and what it doesn't say in the sense that it does generally give quite a positive picture about children's access. Obviously, like there are real questions that have been raised around the table and even real questions in the draft, and I know it's going to be revised, but it is a national look. It is comparative to kids with different kinds of insurance without an absolute sort of look at access and whether it's good or bad, but just whether it's as good as comparison populations or better than other comparison populations, and it can't possibly -- it does not at all, and can't, I guess, with the data that is available and the same sizes and things, look deep for specific problems around specific specialties, dental, other sorts of issues, and I just think we have to be extremely clear about that limitation up front so that we are not inadvertently, for those who skim, including me, to walk away with the wrong impression.

CHAIR ROWLAND: Well, we're also not saying that ESI is the perfect standard, either. So, I mean, I think one of the things that can be stressed over and over is we're doing a comparison here, but we don't have the gold standard of what care should be and we know there are problems across all sectors of our coverage, whether you're uninsured or on ESI or whatever.

And now Denise.

COMMISSIONER HENNING: Kind of a minor point, but it looked like they added a paragraph on the demographic and socioeconomic characteristics. In that first couple of sentences, it references

Figure 2. What they're talking about doesn't have anything to do with Figure 2.

MR. PETERSON: Yes, that was a late-breaking change, so we're --

COMMISSIONER HENNING: Oh, okay.

MR. PETERSON: That's on our list.

COMMISSIONER HENNING: Okay. That was just to see if we're awake.

[Laughter.]

MR. PETERSON: You pass.

CHAIR ROWLAND: And we passed because of you.

Any other comments on access? Going once. Going twice. And let's take a break and then come back to continue with program integrity and financing.

[Recess.]

CHAIR ROWLAND: We really want to talk about program integrity. We're ready. It's been a good afternoon so far and now we're ready to take on a topic that, when it was first presented to us, I thought would be one that was going to be interesting, and it has been very interesting. But I think one of the chapters, in addition to our population focus that we have with the access chapter and with the disability chapter, will be a program management chapter and certainly program integrity and how program integrity is handled is clearly one of our ways of looking at the way in which the program can be more effective.

So, Caroline, why don't you start us through the chapter and then we'll talk about any recommendations that we might want to make in this area, as well.

PROGRAM INTEGRITY OVERSIGHT EFFORTS, COORDINATION, AND DATA

* MS. HAARMANN: Great. Thank you, Diane. Today's session will provide an overview of the draft program integrity chapter for the March report and we look forward to getting your feedback on the

proposed chapter material.

Program integrity consists of efforts to detect and deter fraud, waste, and abuse and to improve program administration. These efforts are important because they affect the quality of care people enrolled in Medicaid receive and the ability of Federal and State governments to ensure taxpayer dollars are spent appropriately.

Many of these efforts and activities have been developed and added over time, and while there are multiple programs and activities that providers, States, and Federal agencies must participate in, these efforts have not always been looked at as a collective whole to evaluate which programs or activities may no longer be necessary or effective. In addition, a number of issues with data use and program integrity efforts can effect the ability of users to identify, quantify, and compare such efforts.

There are a number of agencies at both the Federal and State levels that are involved in program integrity efforts or have oversight authority of the Medicaid program. At the Federal level, this includes a number of agencies within the Department of Health and Human Services and the Department of Justice, and at the State level, this includes the State Medicaid agency and Medicaid fraud control unit and can also include sister agencies, the survey and certification agency, law enforcement, and the State Attorney General's Office, among others.

Some oversight activities relate directly to the administration of the Medicaid program while others assess the program administration and identify areas where problems exist. Agencies may use a number of methods to identify and prevent fraud and abuse, including audits, data mining and algorithms, investigations, enforcement actions, technical assistance and education to State staff, and outreach to and education of provider and enrollee communities.

Coordination of these efforts can help ensure efficient program administration, and it's important because a number of agencies conduct similar or complementary activities and State provider and plan

resources are limited. It's important, however, to note that successful coordination can be difficult to achieve as many agencies have conflicting mandates and goals. A variety of coordination efforts are underway and this session provides a number of -- excuse me. This section provides information about a number of these efforts among Federal agencies, between Federal and State governments, and within States.

One of these efforts, which was discussed at the Commission's November meeting, is the Medicaid Integrity Institute, which provides training to State staff on a variety of program integrity issues at no cost to the States. The courses cover topics such as fraud investigation, data mining and analysis, case development, and emerging trends in specific areas, such as managed care, pharmacy, or benefit design issues, while others are developed to help prepare States for new initiatives.

Commonly cited numbers regarding program integrity initiatives pertain to the amounts of financial recoveries and settlements as well as the number of investigations and prosecutions. Although initiatives and policies that prevent fraud and abuse are difficult to measure because it's an attempt to quantify something that was avoided, it's important to be able to measure these efforts since the ability to quantify results can play a role in determining the allocation of program integrity resources. Although data may help to identify possible fraud and abuse in the program or quantify the results of efforts, there are certain issues to be aware of when using this information.

This section also provides an overview of issues to be aware of related to the use of MSIS data in program integrity activities, Federal efforts regarding data use in program integrity activities, recoveries made by the OIG, State recoveries and performance metrics, and the results of the PERM program.

As States increasingly move enrollees into managed care, it's important to understand program integrity challenges and opportunities in this area. States cannot delegate to plans their federally mandated responsibility to ensure appropriate payment, access, and quality. States use their contracts with plans to require them to comply with both Federal and State requirements, and often to implement strategies

designed to guard against fraud, waste, and abuse. Plans may use outside vendors, internal staff, or a combination of both to conduct reviews to identify areas where fraud and abuse may have occurred to target investigations, and they also commonly use telephone hotlines for enrollees, employees, and providers to identify issues.

The extent to which States coordinate their program integrity efforts with plans varies, though this can include regular meetings to discuss emerging trends, share information, and ensure plans are up to date on applicable regulations.

The Commission plans to continue to examine program integrity efforts in the future. This will likely include examining efforts to coordinate program integrity activities across the Medicare and Medicaid programs, approaches to streamline and effectively manage the program, and efforts to address waste in Medicaid. The Commission will also continue to examine program integrity issues related to managed care as well as the Medi-Medi and PERM programs.

Based on issues identified in this chapter, there are currently three recommendations that are being proposed. The first is the Secretary should ensure that current program integrity efforts make efficient use of Federal resources and do not place undue burden on States, providers, or managed care plans by determining which current Federal program integrity activities are effective, taking appropriate steps to eliminate programs that are redundant or outdated, and creating feedback loops to simplify and streamline regulatory requirements.

The second proposed recommendation is, the Secretary should expand the training efforts at the Medicaid Integrity Institute to include distance learning and additional courses addressing program integrity and managed care.

And the third is, the Secretary should improve information about the results of program integrity activities by issuing guidance to States regarding how to quantify program integrity activities that prevent

fraud, waste, and abuse, and evaluating and disseminating information on the most effective analytic tools for detecting and deterring fraud and abuse.

CHAIR ROWLAND: Thank you.

Judy.

COMMISSIONER MOORE: Thank you, Caroline. I think this is a good chapter and I think it's good that we've added a little managed care emphasis, which from a -- which we had kind of left out in earlier drafts. It's an important topic to assure that we've got an effective and efficient program, and I think it's time that we took a look at this because we added so many statutory requirements over the years that there is -- there appears to be some duplication and overlap that we should take a look at.

So I'm very comfortable with the recommendations. We may need to do a little wordsmithing at some point, but I think they look fine.

The chapter itself has a lot of useful information. I'm wondering if there could be a little added section that describes the agencies involved -- especially since we're concentrating some of our attention on overlapping duplication -- that actually describes the various agencies and their roles and responsibilities. We've got that very nice chart, but it's just got little X-es in it rather than a few sentences on each of the agencies and what they actually do. And then I think that sets up better the description in the section on coordination. So we might consider that sort of thing.

But overall, nice job.

CHAIR ROWLAND: Okay. Donna, Patty --

COMMISSIONER CHECKETT: Yes. Caroline, excellent chapter on something I actually didn't realize was as extensive as it is.

I was really intrigued, and I think we have it picked up in recommendation two about the Medicaid Integrity Institute, and one of the things I like about this is that this seems so doable. It just seems such a

logical thing to suggest. So if you could put any additional information in the chapter about -- I know it says that they, I guess, train 2,200 staff, but over the course of how many years, at what cost. How do States get to send their staff? And it would probably not be possible to do, but one of the problems with training programs like that is that then you train someone and then in 18 months, they're gone and you're back to zero again. Thus, the great things about having webinars and other programs like that. So if we could just maybe get some more facts in there about the whole aspect of that. I don't know if there's anything on, like, at what cost we're flying people in and training them and are they there for a day or are they there for a week. Maybe just some things that would give some more color to it, because I think this could really be a recommendation that could get moved on fairly quickly. Thank you.

CHAIR ROWLAND: Okay. Patty.

COMMISSIONER GABOW: [Off microphone.] -- along the same line for all of these agencies that are listed here. We don't have what it's costing us for all of these, even what their budget is and how many people they have. For some of them, we -- for one of them, we have what the amount was.

But I think one of the things I would suggest right at the beginning where it says the purpose of this, we should ask that we have an ROI on this investment, or at least a metric or some metrics. But we really don't know what all of these are costing us and how many people they have, and I think, to your point about, well, what did this entity really do, I think that would be good.

The draft chart that has all of this on it, I agree that we need a little more about what all these letters are on the side. But I also think some conclusion -- as a general comment, I think in all our work, many of the figures don't really have a figure legend and it really helps to have a legend to every figure.

So I asked a question. So could we conclude that, say, conducting fraud and abuse control is in nine entities as you go across the line, and so pointing out some of -- you know, I was really having trouble saying, well, really, are nine different entities doing this same task? If that's true, it would be probably good

to point that out. Are we all tripping over our shoelaces? Those were my main --

CHAIR ROWLAND: Andy and then Steve.

COMMISSIONER COHEN: I also thought it was really nice, clear work on a muddy and complicated topic, so good job.

My question is, I think -- or comment, I think -- I think we could do a little bit more looking at the money incentives here, and so that kind of goes to two angles. One is certain kinds of fraud, anti-fraud enforcement efforts, like, I believe -- I'm going to say MFCU. I don't think we say that anymore. That may not be the politically correct term. The Medicaid Fraud Control Units get, like, a 90 percent match for their activities, whereas like program administration, the people who might write the guidance in the first place get -- program administration tends to get a 50 percent match, no matter what State you're in. So I was thinking a little bit of discussion of, like, what the match rates are for different kinds of activities and whether that might incent certain kinds of behavior to detect fraud on the back end as opposed to stop it on the front end, that kind of a thing -- and really, I probably mean more like abuse than fraud -- I think would be a worthwhile addition to the chapter.

And then the other question is sort of where recoveries go. Again, it's the sort of question of whether there are some built-in incentives to actually recover on the back end rather than preventing on the front end. That probably is not, on the whole, great for our system. You know, I think recoveries often are treated very differently than kind of like initial monies going for outlays at the State level and at the Federal level, and I know certainly in New York State, for example -- this doesn't go necessarily to where the dollars went per se, but fraud recoveries actually uses the technique of sort of balancing an 1115 waiver target, you know, having fraud recovery targets. So that's attempting use of really beefed up fraud enforcement to get money on the back end if it helps you to sort of balance your 1115 request.

So anyway, I think that some of those issues may go to not quite the right incentives on where we

catch our fraud, waste, and abuse.

CHAIR ROWLAND: To follow up on Andy's point about the administrative side and matching rates, is there a feedback loop where the program integrity people give some advice back to the program managers about when you see this kind of a provider or spot, I mean, we might want to look into that, as well?

Steve had a comment, and then --

COMMISSIONER WALDREN: Yes, so two, one that quickly follows up on Donna and Patty's. My comment was kind of, again, about the table that has all the different Federal agencies and State. In our recommendation, we've asked the Secretary to look at those things inside HHS and that affect HHS. But I wondered, do we as a Commission want to look at across those other agencies and do we want to have a follow-up later to stress, well, we say that there's kind of a hodgepodge of this kind of built up over time. Do we want to really look at this as a more rational thing, look across these and say, this is what we would recommend to Congress relative to these other agencies.

And then my other point about the HIT, two things. One, I think we could put some data about where we're at relative to meaningful use in some of the Medicaid things. We've got about, year end, about 49,000 eligible professionals in Medicaid that have adopted the technology -- that are working to adopt the technology and about, I think, 8,000 -- no, that's not right. There's a number of hospitals, also. So you could show that that process is happening.

And then the other thing about the HIT component of it is the notion that it's not as much you build it and they will come, that there has to be some looking at HIT relative to how it can work with and support the fraud, abuse, and waste components. I think we talk a little bit about that, but being explicit to say that the technology has to be designed to kind of support that. It's just not going to do it right out of the box.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I just want to follow up on Donna and Andy's point, because I think the more we -- and Diane, you have started this, I think, properly to frame it as a program management issue, because it is sort of at one level almost appalling that we spend money, significant money on the Integrity Institute but we don't have an institute on program management. And the day-to-day operation of this complex program requires that, and I think we just have to frame it that way. And when you talk about recovery money, what if that recovery money was reinvested in ways to build capacity in Medicaid agency and professionalization of the staff.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I think that one thing that may be useful to point out is while they talk about waste, abuse, and fraud, I don't think there's very much effort in waste, as demonstrated by the number of entities that are doing this. But in the whole delivery model, in all seriousness, you know, we're very much into Toyota production or lean. Since August of 2006, we're up to $135 million of hard financial benefit by removing waste from our system, and we're one system. And as we remove waste, our quality line actually parallels our waste reduction.

But I don't think that any of these programs really look about removing waste in the whole delivery model in any meaningful way, and in many ways, that's how you improve quality of the delivery system. That's how you engage employees in a meaningful way. I think it's very hard to say that fraud and abuse investigations necessarily improve quality or make employees feel more engaged.

So I think somehow saying there's a balance here and we may have somehow missed the balance of the waste that is in the delivery system and in the payment system because of the complexity and the lack of coordination, et cetera.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: Well, the other thing, it's a great chapter and it was a lot of fun, actually. It was a lot of fun listening to the presenters that came to talk to us. That one guy was just so incredibly excited about his job.

But one thing I kind of find missing is that there's really not a whole lot of training of those of us that are actually providing patient care. I know diagnoses. I can diagnose gestational diabetes and I can diagnose an ear infection. But when it actually comes to assigning a level, a CPT level to that visit, I have a really hard time. And, you know, I'm the President of the Midwifery Business Network. I should really know how to do this. But the only people that really seem to understand it are people that are certified professional coders. And even those people, unless they are also in OB, they don't understand it because OB is such a different animal than primary care.

So I think that maybe providing some education to the actual health care providers so that we don't make stupid mistakes that aren't really intended to be fraudulent but could get me wearing the orange jumpsuit --

CHAIR ROWLAND: Which is actually the point Dr. Hazel made when he was here, as well.

COMMISSIONER HENNING: Exactly. You know, you just don't know what it is you're doing. You're just, like, picking a code and hoping it's the right one.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: Richard and I were actually laughing a little earlier about the fact that there is nothing new under the sun and there was a Medicaid -- and Diane and I have talked about this, too -- there was a Medicaid Management Institute and actually an agency before there was a HCFA or a CMS in the Nixon administration which did, in fact, look more broadly at the administration of the program and try to do a lot of training and work around best practices. And it may be that -- you know, I really was laughing about it before, but it may be that as we think about future work and expanding technical

assistance and innovative activities throughout the States and in the Federal Government and more uniformity in the Medicaid program, that we really ought to go back to thinking about that as one of our sort of next steps around the area of the management of the Medicaid program. Look at the past.

CHAIR ROWLAND: We certainly hear around implementing the Affordable Care Act that the States are looking for not reinventing the wheel but getting some help at figuring out which systems to use, and maybe IT is a good place to look at how that learning has gone on, as well. But we're on program integrity.

Other comments? Richard. Steve.

COMMISSIONER CHAMBERS: I told Judy that we were in the process of moving offices and I came across her book, or Lu, MMI manual from 1970-something, and so I should have brought it back and shared it with you all, but --

[Laughter.]

COMMISSIONER CHAMBERS: I will just make one quick comment, as I've said before, is that I think it's going to be addressed in some sort of setting up for the recommendation on the Institute as in the managed care, where there's the possibility of utilizing those webinars where you can actually expand the audience, with managed care being the administrators of Medicaid in many ways is that where the plans can get the best and the brightest thinking on how they can play a role, because you know that Richard and Patty talked about the return on investment. I get a call a week from, I think, from a vendor who has a ROI of at least ten to 20 to 30 to one for how you can do clean screening and it's, unfortunately, they usually charge about a 25 percent commission on anything that they stop or collect, which is a pretty high fee and I think there's ways that we could find in the dissemination of this information are best practices of where CMS could be helpful in finding ways to make it more cost effective, less dollars that are being removed from the system that should be there.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: I think Richard's point brings up the fact that we should not forget that what we're really talking about here is a corporate compliance tool, and I think the question for the Secretary is the efficiencies of developing compliance mechanisms so as to both put providers at some greater ease and improve the efficiency of the cost of adopting compliance mechanisms. I mean, I think that's really -- in this case, the best practice is really also a corporate compliance mechanism that meets Federal specifications, so --

CHAIR ROWLAND: Any other comments? Any other suggestions? Feedback on the draft set of recommendations we're talking about?

I think, Caroline, you've done your job. Good work. Thank you.

And now we get to the issue that we just really think is so simple that we can probably get through it in about five minutes, maybe, which is the intricacies of the interaction of the State share of Medicaid financing and the payment system and how it all works, and so we're going to have Jim start us with a walk-through of the chapter. This was not a chapter in which we had any direct recommendations on this issue, though we will then secondarily talk about CHIP financing where we are contemplating whether or not to have a...

MEDICAID AND CHIP FINANCING

* MR. TEISL: Thank you very much.

The purpose of this session is really twofold, much like with the other chapters. We want to review the draft chapter for the March report. At this point we've split the chapter into two separate sections: the first one is tentatively titled "State Medicaid Financing and Implications for Payment," and then as Diane mentioned, Chris is going to talk about the section entitled "Federal CHIP Financing." And

then, second, obviously, to obtain your feedback and guidance on the proposed chapter material.

In this chapter we begin to explore the interaction between the way that states finance their Medicaid programs and the ways that they pay providers. We outline the primary approaches that states take to financing their programs, and we focus some on supplemental payments made by states to certain providers.

We're looking at these issues for a couple of reasons in addition to, of course, providing hopefully a useful overview of these issues. First, states' decisions regarding their use of these legally permissible financing approaches affect their methodologies for paying their providers as well as the amount of their payments to providers, and those payments in turn have an effect on access to services for enrollees.

Second, a better understanding of both state financing and provide payment helps policymakers identify and implement policies that most efficiently and effectively promote access to both appropriate and high-quality services.

So a little context and history on the issue. In fiscal year 2011, combined federal and state financing for Medicaid totaled $406 billion. Again, in fiscal year 2011, that split was about 64 percent federal and 36 percent state. We have made this caveat a couple times in the last few meetings. Generally, the federal share of Medicaid is about 57 percent. It was a little bit higher in fiscal year 2011 due to a temporary increase in the FMAP.

Regarding history, statute requires that at least 40 percent of the non-federal or state share come from the state and up to 60 percent may come from local governments, and this section of the statute is in recognition of the fact that there was a combination of State and local programs that existed pre-1965 to provide care for the low-income populations.

A quick reminder on federal financing, and we cover this relatively quickly in the draft chapter. Federal Medicaid spending is determined by the amount that states spend. The federal share of service

costs is determined by each state's Federal medical assistance percentage. This is determined annually for each state and provides higher matching rates to states with lower per capita incomes relative to the national average. Administrative costs are generally matched at 50 percent, and that doesn't vary by state. And as was just mentioned in the previous session, some administrative costs -- Medicaid management information systems, medical professionals utilization review activities -- are matched at higher rates.

We covered a lot of these state -- we covered actually all of these state financing issues in our November meeting, so I'm not going to go through in detail what all of these are again, but the chapter covers the multiple allowable sources of non-federal Medicaid financing that states use, and those include state general revenue, local government contributions, and health care-related taxes.

A couple of key points in this area. The law provides states with flexibility in financing the non-federal share. About three-quarters of non-federal spending is state general revenue, and state vary in the extent to which they use local government contributions and health care-related taxes. On taxes specifically, these taxes are authorized by federal statute and are now in use in nearly every state, although, as we mentioned at the last meeting, information regarding the taxes, including the tax rates and the amount of revenue generated, is not readily or easily available. This can limit our understanding of the role of these taxes in provider payment amounts, and it can also make it difficult to assess the impact of any potential changes to tax requirements at the federal level.

Regarding supplemental payments -- and, again, as a reminder, these are payments made in addition to the standard payment rate for services -- they tend to be in lump sums, and so they're not necessarily associated with specific services to specific enrollees. And when we talk about supplemental payments, we're talking about disproportionate share hospital payments, or DSH, as well as payments under the upper payment limit, or UPL.

In fiscal year 2011, supplemental payments, including both DSH and UPL payments, actually

accounted for about 40 percent of total Medicaid payments to hospitals. These can be an especially important source of revenue for certain providers, and this certainly includes safety net hospitals.

Data regarding UPL supplemental payments can be hard to come by. The amount of payments based on UPLs and the providers that receive them can't be readily discerned from existing federal data sources. Thus, it's not -- or it's challenging to compare total payments across providers and states, and also it's very difficult to compare the total amount of spending on specific services or populations when providers receive these sort of lump-sum payments that aren't clearly tied to specific services or populations.

Some states have also indicated that the UPL supplemental payment policies have influenced their decisions regarding expansion of their managed care programs, particularly the higher-cost, higher-need populations, and at our last meeting we heard from Billy Millwee, the Texas Medicaid director, who talked about just such a situation in his state.

Looking forward, we hope to continue to examine states' approaches to financing their share of the Medicaid program, the effect of these approaches on their payment methods and rates, and then ultimately be able to evaluate the potential connection between financing and payment and then payment and access. And with that, I will turn it over to Chris to talk about federal CHIP financing.

* MR. PETERSON: Thanks, Jim.

So you've already seen a lot of federal CHIP financing issues in our work. Chapter 3 of our March report was on CHIP in particular, so it was there. We had a MACBasic that was on federal CHIP financing that was released in September. So this is another step building on that and highlighting in the CHIP section that CHIP financing at the federal level differs from federal Medicaid financing in that it is possible for states to exhaust federal CHIP funds, there is no funding for CHIP allotments after fiscal year 2015, and that the federal CHIP matching rate is higher than Medicaid's.

So for the outline that you have a draft of, that subsection on federal CHIP financing discusses

federal CHIP allotments and then the CHIPRA contingency funds.

As was discussed in the MACBasic in September, we had raised the issue -- actually back in March, in the March report, that it was theoretically possible for a state that exhausted its federal CHIP funds to get a payment from the contingency funds that was greater than the amount that they needed in shortfall. So that was a theoretical possibility when we raised it in March, and then it did occur, and we mentioned this in our MACBasic in September. So in light of that, there is a draft recommendation, the wording of which is: The Congress should amend the CHIP statute to ensure that if states exhaust their federal CHIP funds, they would receive a payment from CHIP contingency funds that does not exceed their shortfalls.

CHAIR ROWLAND: Thank you. So let's first start with any comments on the first part of our discussion, the supplemental payments in Medicaid and provider payment issues and states' share, and then we'll take up the CHIP.

COMMISSIONER ROSENBAUM: First of all, just to reiterate what we have told you before. We heap praise on the head of Jim Teisl who is dealing with one of the most complicated parts of the program, and I think that the chapter will be a real contribution when its finalized. A few points which go to its overall tone and structure.

The first one is maybe it's just me, but I find -- and this is going some -- I find no part of Medicaid more jargon-filled than this. This is the worst. I mean, this is when you're into IGTs and UPLs, and people are speaking in such code that everything and anything we can do to unravel the mystery I would, and I might add in like text boxes with basic glossary terms, things like that, just to make life easier for readers.

Second, I think that we ought to view the principal thrust of this chapter as both demystifying issues that have arisen over the years in Medicaid financing and illustrating the ways one part of the program interacts with another part of the program. So it's not -- you really can't get to the causality side of this.

What you do know is that there are connections between things, that the traditions that states have about how they raise revenue for social welfare programs, the kinds of health care systems they choose, for example, states like New York or Colorado that have historically relied -- or Illinois, other states that have historically relied on major public hospitals and health care systems will be influenced in certain directions that might not be so true in a place like, say, Connecticut, where I'm from originally, that doesn't have a long tradition, or at least not in recent years, of being safety net financing, you know, big urban public hospital systems.

So I think we want to explain that there's this long tradition because it goes right to the issue of Medicaid as a way of helping states within their capacity, within their own delivery systems and traditions, to build programs of health care for low-income and vulnerable populations. So everything we can do to sort of in very plain language talk about history, tradition, background in introducing this material and how that has led to various relationships -- and I would suggest a different name for this chapter, which is rather than "implications for provider payment," we want to talk about the relationships between financing and payment.

I also think that one of the things that we've got to point out is that in some cases -- you know, Medicaid's a program where you get knotted up in your own underwear without even trying, and this is a case where we have all contributed through a series of strategic choices to making the knots even worse than normal. So, for example, the whole notion of UPL as a supplement is really conceptually not correct. This is a mechanism for recognizing and paying a higher rate to certain providers with certain characteristics, potentially. And because it was treated as a payment supplement, because it was treated as an add-on, that led to a whole other series of consequences. It was not seen as being tied to payment. It was like some bonus that you got. And that then led to a decision on the part of CMS in part to say, well, if you switch to managed care, that's not part of your payment base, that's some other money, when, in fact,

the money is part of the payment base.

And so we've taken thorny problems in Medicaid, like how to recognize and pay different kinds of providers for the work they do, and by setting up relatively -- what do I want to call it? -- confusing ways of dealing with problems, we've then added to the downstream consequences when the health care system changes, financial conditions change, and you need to modernize Medicaid.

And so I think that this is a case where we don't necessarily make a recommendation at this point, but it's also a case where I think we want to do some plain talking to Congress and to the Secretary and to the states and to the audiences generally that have a big stake in Medicaid, that we've got to sort of clear away all this underbrush and get back to the question of how states pay for Medicaid, how they bear up under the burden of Medicaid, and what some of the issues are that arise in state payment.

COMMISSIONER HOYT: Again, really good job unpacking what might be one of the most complicated issues we'll look at. I think it does reflect layers and layers of layer cake or a patchwork quilt idea of things that have just been done over and amended, and to me, anyway, it just sort of screams that it's time to re-bid or change something. I suppose we're all influenced by our own experience or where we've come from. I don't know how many meetings I've been in with a Medicaid director or treasurer or somebody from the governor's office, legislative persons, somebody who moved from one state to another state trying to understand this issue, and they'll ask us -- or I'm sitting in a meeting where they're saying something like -- or it could be an MCO who's going to contract with the state: "I'd just like to understand the flow of funds from the state and the feds to the hospitals, how it works now and how it will work after I'm under contract to make sure I get this right. Can you do that? You have like a black belt in number crunching, don't you?" No, I can't do that. I have no idea how to do that. Or a Medicaid director says, "I just want to understand what I pay and what I get."

We bump up against that I think some in the paper trying -- on some of the data issues, and at least

it felt to me like an appropriate recommendation might be once you pull all the skeletons out of the closet and kind of lay them nicely out on the table, again, these are all pretty smart people that I've met with, would say, "Are you kidding me?"

[Laughter.]

COMMISSIONER HOYT: Or, "Did you bring Tylenol or something stronger? Because my head hurts." So they can't figure it out, you know, would be the point. And I think the recommendation might be obviously this calls for some kind of simplification here. It is so complicated. Even just the UPL concept that we mentioned, like, "I thought I understood what UPL was, but I just came from this state and they did it totally different." Or, you know, "DSH was no big deal there. Here it's the elephant in the room. It's everything."

But I don't think we're in a position to make much of a recommendation because we don't have some of the data or other things we want. So in my mind, that might be a recommendation, or at least a pretty strong comment in there. But at least for me, I'm kind of uncomfortable with what's really an excellent chapter, and I don't really have anything to say about it, but that's just Medicaid. You know, I'd rather see us say something about that.

COMMISSIONER RILEY: It strikes me it is a tough area and one that's not apolitical, so we have to be thoughtful about the various stakeholders and how they look at this. And I think one of the realities is the Congress created these financing streams often during difficult financial times with the states. So we ought to talk a little bit about the states and their efforts to sort of balance all the responsibilities. And I think we need to add into this the countercyclical nature of the FMAP and that states are really hurt hard because it's too slow in keeping up with the realities of state budgets. So there are cuts that happen during tough recession times when the FMAP is cut. It rises two years later as the economy of a state changes. It makes it very tough to manage this program.

So maybe at issue -- and Andy and I were having, of course, our usual sidebar, but maybe at issue is a bolder recommendation of it's time to take another look at FMAP instead of looking at all these little tweaks and changes we've made in the program, what should -- what is an appropriate FMAP? How ought it to be constructed? And what can we do to make sure it keeps up with the reality of state economies? Because the countercyclical nature makes the program that much more difficult to manage.

CHAIR ROWLAND: Well, actually one of the things that NAMD has also raised is to look at what all the differential match rates are within the Medicaid program and what incentives are provided in some of those and not in others. So that may be something worth doing.

COMMISSIONER CHECKETT: I know the paper touches on looking -- I just checked the language, that in the future we'll look at the relationship between UPL and it's in the context of the tough choices states sometimes have to make about whether or not they can do capitated managed care because of the UPL payments. And I think that's a very important issue because we're trying to recommend to Congress and to the Secretary that we want to encourage and make easier ways to run efficient, effective programs, and yet we have this massive funding issue that states cannot walk away from this money. And so I would just like to throw out for the Commission's discussion that we reconsider or consider some recommendation of looking at that as well.

COMMISSIONER HOYT: I'd second Donna's point. I thought that was good.

Sort of a question for Trish on what she said about the FMAP. Is there something fundamentally flawed with the way FMAP is designed now? Is FMAP really the core question? Or are we using it to get at something else? To me, it's more than just how FMAP is set. What do we apply FMAP to? There are so many different schemes out there to build up these expenses to apply the FMAP to. That's key.

COMMISSIONER RILEY: Well, Mark, it's probably a question beyond the thrust of -- it really is if we did a real financing paper. Do we need to modernize the financing? Because we've done this

patchwork of ways to fund the program. But regardless of whether we take -- and whether FMAP should be the only vehicle as opposed to all these special funding sources, I think those are all legitimate issues for us to deliberate. Independent of that, though, I think the countercyclical issue is a real one that we know is a problem today. It's a small part of the problem. But I think those are real issues we ought to have if we want to talk about a financing chapter, but I do think this is -- Sara's right, this is more about the interrelationship and a more narrow view of this.

CHAIR ROWLAND: There have been occasional large studies of ways to redo the FMAP that HHS contracted for, and I think one of the problems is redoing it has winners and losers, which is hard but probably much more effective, and I think a model for that might be what just happened with the calculation of the poverty index where we had an alternate developed that was more in tune with the real expenses, and so maybe that's something we really should put on our long-range agenda.

COMMISSIONER RILEY: And I want to be clear. My proposal was no losers.

CHAIR ROWLAND: No losers.

COMMISSIONER RILEY: An FMAP that takes all the money and makes sure there's no losers, so it would be easy to do.

COMMISSIONER GABOW: Well, I think that a conclusion -- maybe not a recommendation -- is that when you look at all of this piecework and how it's grown up, that it may be coming time to step back and ask is there a more rational way to finance this program, and that's something that we would like to consider as we go forward, because I think that is the conclusion that you draw.

Another conclusion that might be drawn around this whole UPL and managed care is that -- you probably know. I don't know exactly how many states now have a waiver that is getting around this, certainly Florida and Texas, I mean, there are others -- that a conclusion might also be without a recommendation is that once a state has a waiver to solve a critical problem, the delivery system, that it not

have to be re-examined ad nauseam. Again, maybe it's a way to say, well, okay, this is an issue that everybody's trying to deal with here, how we're going to deal with it from the federal government.

I mentioned earlier -- and I just want to underscore it again -- that I do think in the chapter we have to discuss how critical these funding streams are for the safety net until we get a more rational way of paying for things, and that without these funding streams the majority of the safety net would be substantially in the red and be unsustainable.

I would make a broader general comment. I like the format of this chapter, and we maybe should think of standard work for all our chapters that, you know, the idea of having sort of what are the key issues that we're going to hit, what is the work that the Commission has done before to set this up, and then I like the idea of always having a basic glossary of terms, because it doesn't matter which area we're going to be in, there's a lot of terminology that nobody would be expected to know. So it's like that last chapter where we had all the agencies and who knew what they were.

So I think thinking about a standard format for all of our publications, start out with saying here are the key issues, here's our previous work, and then dig in would be useful.

CHAIR ROWLAND: Great suggestion.

COMMISSIONER CHAMBERS: I'll start by just quoting the late Senator Chafee, who once said at a very long hearing that everything has been said but everybody hasn't had a chance to say it.

[Laughter.]

COMMISSIONER CHAMBERS: So I'm going to be one of those people and agree, is getting at the core of the fundamental financing of the program. I remember when I was in CMS in the late 1990s, one of the regional offices, an audit of a state -- I won't say which one it was, but, you know, their match rate was -- their FMAP was relatively high compared to other states, but after they figured out all the funding streams, the state really had a 110 percent federal matching rate.

And so I said, "Well, the solution is why don't we just federalize the program. We'd save 10 percent because we'd only spend 100 percent." But it really has gotten so skewed. You know, you see decisions that are made at the state level which are based on going to the money as opposed to what is being invested in and what it's being used for.

I think it's particularly -- many states are probably seeing where states are still focused on finding the federal dollars, is it preoccupies everything else they do. It almost goes back to the management of the program when you're just rushing to the money, is what else are we missing. So it's as tough, tough issue because I see the day, the way things are going, where it's going to be all losers when you redo either FMAP or something, because if states aren't doing creative financing programs -- you know, I used to always say a Medicaid director should be fired because if they're not doing, you know, taxes and donations and stuff like that because there are some that do and some that don't, and the ones that aren't are just being disadvantaged. I think a more rational way of being realistic that there's a lot of -- you know, the paper talks about that one chart about it was 65/35, I think, the matching rate, but you had to take into consideration the temporary increase that was in place under mid-2011 -- or mid-2010. But the issue that I'd say even today if you went back to the traditional 57 percent federal match, I doubt it's 57 percent. It's probably 67 percent. But what you see on the books is all of these transfer programs and tax programs, which hide, you know, what is a real contribution of the federal government versus a state, and to be realistic about the money in the system. I know that's not going to be easy, and it's very politically charged, but ultimately we have to get to designing a system that's financed appropriately for the right outcomes and providing services for the right populations.

CHAIR ROWLAND: And we all should be reminded of the controversy that went on over the blended rate proposal that was on the table earlier in the year and the blending of the FMAP. So I think those are the issues that we get into.

VICE CHAIR SUNDWALL: This is really interesting. Having been responsible for a Medicaid program in a state that doesn't do much creative financing, we always felt disadvantaged. And, of course, we don't have the degree of poverty in Utah, but you used a phrase that I think came up repeatedly: "gaming the system." So I've learned in the preparation of this chapter that there's a legal basis for all of these things, and we've made that clear in the chapter. This is not illegal. These are mechanisms that have been developed over time, but that doesn't make them right.

I couldn't agree more with the comments we've already heard. The charge of the Commission, I think we've all agreed, is trying to promote simplification, address complexity, and I don't know, Patty, you said we need at least a conclusion, but I would be strongly in favor of our saying notwithstanding the legality and the history and the importance to the safety net, we think this calls for reviewing how we financing.

I'd like to know the amount of money and hours spent doing this creative financing. It's a very complicated and unnecessarily costly way to get federal dollars. So I hope that we at least make a conclusion that we need to address this head on.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I just -- I never like to disagree with Richard, but I'm trying to -- I'm still grappling with the notion of the Federal match is really higher. Even though States use these other provisions, they still match it, and so implicit in your assertion is that those dollars don't count as State dollars and they are. They're taxes generated by the State. A State dollar is a State dollar generated in very creative ways, to be sure. But I don't think it would change the percentage.

COMMISSIONER CHAMBERS: I'm just getting at the fact is, particularly when you have provider taxes where the providers are reimbursed 100 percent for the taxes that are counted as State dollars and there's really no State dollars. And then you get States, and I won't say which one it is -- it happens to be the one I live in -- but is they actually on intergovernmental transfers charge a 20 percent processing fee.

So they hold back 20 percent of the dollars. I hope I'm not revealing anything. But, I mean, it just sort of is -- the incentive is that those dollars get counted as State matching dollars when the provider is paid back 100 percent of the dollars that they paid in the tax and the only new dollars in the system are the Federal matching dollars. And so I just think that just skews the -- that's counted, I think is the way CMS counts it, those dollars that were raised by the taxes are considered States' contributions, correct? And I don't see how you classify those as real State match to me.

But it's back to David's point, is it's all legal. There is nothing -- I'm not accusing any State of breaking laws and people should go to jail, but it's just -- it's created really perverse incentives of how to finance.

And then it's back to, you know, what goes to safety net providers and upper payment limits and, again, it's not -- it goes for good purposes, but are you always investing the dollars in the right way? There is a write-up in here that talks about the Texas waiver and the thing about the DSRP program, as they call it, which is California's waiver of 1115 has the same thing, in which it's trying to reinvest some of the dollars into reforming safety net delivery systems to become more efficient and coordinated, I mean.

So I fundamentally agree on that. Let's take the dollars and invest it in something that's going to have a bigger impact in the long run rather than continuing just to do the same things over and over again. That's personal opinion and I know not everyone agrees with it, but I'm sticking with the story.

COMMISSIONER COHEN: I just want to throw my perspective into this conversation, and also having worked sort of on both sides of this for the Federal Government and now in a locality that pays a very substantial part of New York's non-Federal share, this epic struggle between the Federal Government and the States, and in one case the localities, as to who pays how much of the share of Medicaid is going to be with us as long as the program is in the format that it's in, is exceptionally political, is epic. And I actually, myself, I'm not sure yet what the role is of an expert panel in tackling those issues.

We can certainly illuminate a lot of issues about -- the way I sort of look at it is I don't really -- I'm not sure yet where we can add value in figuring out where the dollar came from, but we certainly can add value in saying what the dollar goes for, and that's what I think the chapter should focus the most on, which is to the extent that there are financing rules that distort what the dollar is spent on and make it not efficient, not purchasing quality care, not transparent so we have no idea what we're buying, those are the issues that I think we should highlight and see if there are solutions that we can get around.

But I think sort of for our purposes, it is like really an epic sort of political discussion around where the pieces of the dollar come from and I'm, at this stage in our sort of, like, analysis and development, I'm much more interested in where the dollar goes.

COMMISSIONER CHAMBERS: Thanks. I was just going to say real quick, Mercer's seen plenty of cases that would back up what Richard just said about, you know, if you really tally up everything, like we would do this typically in conjunction with preparation or filing of an 1115 waiver, try to get your arms around all the money flows in every direction, you would see FMAPs.

I remember the first time I did this, myself and another guy who were doing this felt like we made an error or mistake. We got extra peer review and everything else. We couldn't figure out what was going on because it was 15 percent higher than the FMAP rate. So we just thought when we were done, if you blocked all this out, it ought to be somewhere in this range and it just wasn't, and that was the first time we really got this. It's absolutely true.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: Well, I think I have a couple thoughts. I got to grasp my -- put my head -- I guess, first, Andy, I was really struck, are you questioning why we're doing the chapter at all?

COMMISSIONER COHEN: No. I think I just see the focus of the chapter -- I would like it to

be more, and I think it is largely there, but it's on where, like, a financing rule may distort where more appropriate decision would be on spending, you know, and the example being all other factors might suggest that the best programmatic decision for Texas was to put more people into managed care, but the UPL rules, you know --

COMMISSIONER CHECKETT: Okay. All right.

COMMISSIONER COHEN: -- just sort of that --highlighting those kinds of issues, flagging them and maybe thinking of solutions to deal with them, but not getting into --

COMMISSIONER CHECKETT: All right. Okay. Not getting into the effective effort. Right. Okay. And then I want to just emphasize my concurrence with that, that it's -- we need to be focusing on specific recommendations that can be implemented in the near future as opposed to taking on the philosophical question of how do we finance in general a program and who should finance it and it's just really beyond the scope of, I think, what we're set up to do and I would have a lot of concerns about that.

And I know we've discussed on and off, and as a person with so many years in State government, I just really want to make sure we say loud and clear and set the context, and I think Trish raised this before, that States can't borrow money. They don't have a credit card. And they have many, many competing forces. I dare say everybody in this room can borrow more money than States can. So -- you know, because we've all probably got credit cards. So I just think we need to be really clear that the challenge of having this enormous entitlement program and trying to finance it and we've got this financing mechanism, so anyway, thank you.

VICE CHAIR SUNDWALL: Let me just give you an example that happened this last week.

COMMISSIONER CHECKETT: I think they can borrow money. They can't have a deficit. Sorry.

VICE CHAIR SUNDWALL: This happened last week in Utah. The Governor was in a press

conference and was asked why we aren't spending more on education. He flat out said, "Well, if I didn't have to spend $76 million more this year on Medicaid, I could." And it just puts it in such a bad light, but it's the big, bad Pacman that's just gobbling up the money. Yes. So that's exactly what the problem is, that States are in a hard position.

COMMISSIONER CHAMBERS: Could I just -- I just want to sort of make one final comment. I'm not saying as I want to see it like the Federal Government spend less on Medicaid. I just -- I think my point is that let's be realistic of what the real match rate is and say if the real Federal contribution is the Feds pay two-thirds to three-quarters of the Medicaid class, because States can, let's be realistic and then let's design a system that's not -- the number of dollars that are being spent on consultants to design these programs and it's just ridiculous. And then what all of us as providers go through, I'm sure, Patty, in Colorado, is we pay taxes, and trying to figure out as how you get the money back and get them out to the right people is just full-time jobs for people. And so it's just a really convoluted way of doing it, so I just -- and pushing for let's be realistic and say let's design, so --

CHAIR ROWLAND: [Off microphone.] -- oh, and then we're going to make recommendations that cost jobs.

COMMISSIONER CHAMBERS: Yes. Yes. No, I don't think so.

CHAIR ROWLAND: Jim, I think you've got some guidance.

MR. TEISL: Yes.

CHAIR ROWLAND: It's kind of all over the place, but I think it reflects the fact that this is such a critical chapter and that there's much, much more to go, but this is a good beginning.

And now I'm going to turn to the CHIP and to Chris because we never like to let Chris off the hook.

Sara.

COMMISSIONER ROSENBAUM: Just in talking about the wording, I -- if you could just read it one more time, what you said at the end, or I don't know if we have a slide on this. No --

MR. PETERSON: Let me just read it aloud. And I think it's the same which you have in your materials --

COMMISSIONER ROSENBAUM: It is, because I think -- I personally feel it would be --

CHAIR ROWLAND: Chris, just read it once more.

MR. PETERSON: Sure. The Congress should amend the CHIP statute to ensure that if States exhaust their Federal CHIP funds, they would receive a payment from CHIP contingency funds that does not exceed their shortfalls.

COMMISSIONER ROSENBAUM: Exactly, and I personally feel that we would be better off, and I think it is a more appropriate way of expressing this, that States should be able to expect replacement up to the actual amount. In other words, not that it does not exceed. I realize that underneath this recommendation, there is a question of excess payments. But I think that what we want to frame the recommendation to Congress is that they should be able to receive replacement funding up to an amount as opposed to the negative, does not exceed the amount. I'm just trying to think of a way to say it that expresses what we want but expresses it in a more positive way.

CHAIR ROWLAND: Or how about that their payment from CHIP contingency funds should be up to their shortfall amount, or something like that.

COMMISSIONER ROSENBAUM: [Off microphone.]

CHAIR ROWLAND: Should only be up to their shortfall amount.

[Off microphone discussion.]

COMMISSIONER ROGERS: [Off microphone.] Only up to.

CHAIR ROWLAND: Up to.

COMMISSIONER ROGERS: Should be only up to --

CHAIR ROWLAND: Only up to their shortfall amount.

Any other -- this is not a chapter on CHIP. This is just really specifically looking at the financing. It's not as complicated as what Jim tried to put before us, but it is very important for people who run CHIP programs.

Okay. Thank you both. Now we'll do some numbers. Thank you, Jim. Thank you, Chris. Great chapters and good points.

So we now have April and Chris Park and we're to MACStats. And we're at Tab 5 in your notebook.

OVERVIEW OF MACSTATS

* MS. GRADY: Thank you, Diane. This will be a relatively short session, I think, compared to the others. As you can see in Tab 5, what we're proposing for the MACStats for March 2012 would largely follow the order and the content of the March 2011 report. So as a reminder, we have the table of contents from March 2011 in Tab 5 there just to show you what we had done last year.

I'll talk a little bit about some of the new information we're proposing to support the March 2012 chapters and then I just want to indicate that all of the data will be updated to reflect the most recent year available. For many of the statistics, that's fiscal year 2009. We do have 2011 in some cases, but it'll vary depending on the table.

So the first notable change I want to point out from last year relates to Table 1 from last year, which is Medicaid and CHIP enrollment as a percentage of the U.S. population. We're going to continue to show the overall U.S. population, but we're also going to add -- we are proposing to add three tables to show breakouts for children under age 19, adults age 19 to 64, and those 65 and older.

The next change we're proposing is to Table 2 from last year. We'll continue to show Medicaid enrollment breakouts for eligibility groups, for children, adults, people with disabilities, and individuals age 65 and older. But what we're suggesting to do is to vary the breakouts for additional selected characteristics to be in support of issues covered in the March report for a given year. So, for example, last year in addition to the eligibility groups, we showed breakouts for dual eligibles and managed care participation. This year, we would focus on people with disabilities in support of the chapters.

In addition to changing those selected characteristics in Table 2 for enrollment, we would add two tables to show total benefit spending and benefit spending per enrollee with the same breakouts.

And as I just mentioned, for these tables with enrollment and spending by eligibility group, we would provide that additional breakout of enrollees with disabilities by dual eligible status. So we'd be showing the Medicaid only enrollees and we'd be showing those who are dually eligible for Medicaid and Medicare.

The next change that we would make would be to provide four additional tables to support the Medicaid and CHIP financing chapter. The first two would deal with the supplemental payment and provider tax issues that we just discussed. In particular, the supplemental payments would be by type of provider. So we'd be looking at hospitals, nursing facilities, physicians, and showing what portion of their total payments come from regular sort of rates and what portion comes from supplemental payments. And as Jim mentioned, I believe, for hospitals, for example, 40 percent of the total payments for that provider are coming from supplemental payments. So that's what this would be showing by State.

The other Medicaid financing table would show the total amount of provider taxes reported by States and it would also indicate which States reported different types of provider taxes, so hospital taxes, nursing facility taxes, to that effect.

I want to point out that both of these tables come from data reported by States. We talked

extensively last year about the CMS 64, which is the accounting form that States submit to receive Federal reimbursement. We need to do a little bit more work looking at the extent to which States are reporting these things. Just because the form exists doesn't mean that all the States report these amounts, so that's one thing that we'll be reviewing before these tables are published.

The last two tables that we're proposing to add have to do with CHIP. They would show Federal CHIP allotments for fiscal 2011 and 2012, including the way in which the CHIP allotment formula is used to calculate those amounts, and we'd be showing a table with the Federal CHIPRA bonus payments that States receive for various outreach and other activities.

So that concludes the presentation on MACStats and we welcome any feedback or suggestions you might have.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Just, April, a quick question. Oh, David, go right ahead.

VICE CHAIR SUNDWALL: [Off microphone.] No, no, no. I was just --

COMMISSIONER ROSENBAUM: Just a quick question. I have to say I somehow missed this development, but I notice that there's a new website, Medicaid.gov. So is there -- I probably should have known this, but I didn't realize it until yesterday. So is there any difference, then, between -- do they offer anything more at their site than we do? Is there stuff we should be picking up or any adjustments made because there is this new website? I'd be relying on other people to tell me what the numbers are that matter. I just wonder whether we need to adjust MACStats because of that.

MS. GRADY: Medicaid.gov makes use of all of the same underlying data that we use, so while there may be small differences in the presentation -- for example, when we report Medicaid enrollment, we exclude Medicaid expansion CHIP enrollees -- there may be slight differences, but most of the information will be the same. I'm not aware of anything that's been added to Medicaid.gov that is not already in the

MACStats that we have.

COMMISSIONER EDELSTEIN: April, given that we're doing a chapter on children's access, did I miss it or is there MACStats on the 416?

MS. GRADY: We don't have MACStats on the 416, and I don't believe the chapter addresses that particular data source right now. I mean, just to remind everyone, the 416 is a form that States submit with information on early and periodic screening, diagnosis, and treatment, EPSDT measures for children of which dental is one, and CMS has been working a lot on revising those measures. But, no, at this point we don't have 416, and I would imagine in the future if we have a chapter on dental or one that substantially addresses it, it's certainly something we'd want to --

COMMISSIONER EDELSTEIN: Yes. I wasn't thinking of dental per se, actually.

[Laughter.]

COMMISSIONER EDELSTEIN: But that's as close as a Medicaid data set comes to reflecting what we discuss in that chapter.

MS. GRADY: And I think we can talk internally about the state of that data and whether we want to add another table to support that chapter.

COMMISSIONER CHECKETT: Two questions for April and perhaps for Lu, too, would be just do we feel like we're picking up everything we need to be picking up? For instance, have we heard from Congressional staff that I love MACStats, but this is the one piece of information I don't have or not?

And let me throw out, at one point in my career when I was a Missouri Medicaid director, we got a lot of great feedback by having a one-pager that was like the top ten things you needed to know about Missouri Medicaid and everybody had it and it was -- you're nodding your heads, but, I mean, people loved it and people had it pinned on their bulletin boards, and it was how many people and how much does it cost and what's the eligibility. People always need to know that FPL number. I'm just throwing that out

there. Maybe we're doing that already, so anyway. You probably are, since you're nodding your head.

MS. GRADY: No, it's something we really want to do, a one-pager that gets out the key facts, and we've kind of done it a little bit in some of our press releases and some of the key points about the books that we did last year. But that's something we definitely want to do and I think it's a great idea.

COMMISSIONER CHECKETT: [Off microphone.] It could be a little insert --

MS. GRADY: Yes. Yes.

CHAIR ROWLAND: Years ago when I worked at HCFA, we had cards the size of a credit card that had all the key numbers on them.

MS. GRADY: Yes. Yes.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: I just want to put in a plug for Medicaid.gov. I don't know how many of you have visited the site, but it's good and there's State -- there are pretty colored maps and you can punch your State in and see this data. I'm assuming it's as good as ours or whatever. I don't worry about the nuances. But they're to be commended. It's a user-friendly website that I don't think has been available before.

One thing, and this is kind of relevant, I hope, but Diane, I want to ask you about the Kaiser report I saw came in my e-mail today about how States have, notwithstanding the downturn in the economy, maintained pretty much their level of service. I guess the legal requirements, of course. But what kind of surprised me is it seemed like it was putting a positive spin on, with the economy and all the pressure, they still kept up with eligibility and services. But what struck me was, because I know the Utah data has been like this rocket ship going up with enrollees, has it not gone up or has it just been kind of level in this time? I should have thought, given this countercyclical thing, there would have been quite an aggregate increase.

CHAIR ROWLAND: Well, the enrollment clearly went way up throughout the recession and it's

somewhat leveling off in terms of its growth right now. But what that report was really about was the procedures in place, and I think the big improvement there is States really embracing more of the IT and simplification so that they were being much more efficient in their enrollment practices and that was where the big level of improvement was and starting to get ready for having new systems and investing in new systems. And one of the folks that spoke from South Carolina talks extensively about the improvements they were making in their IT systems were improvements that would apply to the current population even if they never took on the expansion population, so that that was really where we saw the most progress.

VICE CHAIR SUNDWALL: You raise another issue. Andy was saying earlier that we want standardization of program integrity, you know, capacity, or the tools we use to do that. Is it the role of the Commission to promote some standardization of these MMIS systems, because they're so darn expensive and, you know, I feel like we and other States have just invested heavily in ones that didn't work and you had to retreat and try again. I think there has been some effort to get regionalization or some standardization, but it seems to me that's, in the spirit of simplification, something we ought to weigh in on at some time about these data systems, HIT. It could be much better.

CHAIR ROWLAND: It might even help give April better numbers to work with.

Other comments? Mark.

COMMISSIONER HOYT: I don't know, just sort of a random thought, still thinking about the FMAP discussion and then these MACStats. I don't know if this would be hard to pull or not, but I'd be curious to see if we could get all the Federal expenditures for Medicaid that flowed into States and then pair that with the total State expenditures, which I think we had on the slide already. I don't know if that came off of 64s or somewhere else, and then just do the simple math and go, does that equal the 57 percent five years ago or 63 or whatever we say it is now, because that might be revealing.

I'm guessing that the quoted figures on what the weighted FMAP is now is derived differently than

doing that math, of looking at all the Federal dollars that went towards Medicaid and just calculating directly what percentage of all the spend on Medicaid that is. But I'd almost bet you a difference in the quoted percent.

CHAIR ROWLAND: Any other comments? Any response to Congress asking for things that are not in MACStats?

EXECUTIVE DIRECTOR ZAWISTOWICH: Generally, we've gotten very positive feedback about MACStats. They want more and more, of course. And I think we've hit a lot of the issues that they're very interested in. I mean, there are some things that we just don't have data on or that we're trying to refine the data -- home and community-based services, getting a better breakdown on that. They are interested in more data on provider taxes, you know, something that we're looking at. But again, the data are limited. They're always interested in getting a better handle on State plan services and what States are really providing, again, something that we are exploring and working with CMS.

Anything else, April, that you can think of?

MS. GRADY: No. I think the feedback has been largely positive. I think the all in one place is what's been a good thing for them.

CHAIR ROWLAND: Thank you.

And we have a very attentive public here. Are there any comments that the public would like to offer to the Commission?

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: Did we bore you? No? Okay.

Well, we thank you for coming. I think you now have a pretty good overview of the upcoming

March report. The Commission will also be looking at other issues. We're anticipating potentially more work on maternity care and on dual eligibles as part of our June report. But we really need to get our March report settled and that's what we're in the process of doing now.

Our next meeting will be in February, February the 16th, and so we hope to be much farther down the road with both the report itself, but especially with our recommendations and to be voting on any recommendations that we will be making at the public meeting in February.

So I thank everyone on the Commission. I thank the staff for the outstanding work once again that you have brought to our table and to our computers over the last few weeks. You have much more to do, we know, but we really do appreciate your willingness to take our comments and then to turn them into a very logical document. And we thank the public who came to listen to our discussion today. And so we're adjourned for this evening.

VICE CHAIR SUNDWALL: I want to thank Diane for letting us out early. This is great.

[Whereupon, at 4:38 p.m., the public session was adjourned.]