MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

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

Thursday, April 19, 2012
10:21 a.m.

COMMISSIONERS PRESENT:

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

LU ZAWISTOWICH, ScD, Executive Director

AGENDA PAGE

P R O C E E D I N G S [10:21 a.m.]

CHAIR ROWLAND: Can we please reconvene as our first panel has some time constraints associated with it?

We're very pleased to welcome to this meeting of MACPAC, once again, Rick Kronick, the Deputy Assistant Secretary for the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services, so we can keep going with the titles, as well as Nancy De Lew to accompany him.

And we're aware that our time schedule with Rick is a little more constrained than previous, but we wanted to start with this session because as a commission we are trying to lay out our research and analytic plans going forward, to look at the kinds of issues related to access to care that we as a commission should take on. And we always benefit from knowing what other parts of the Federal Government are doing and engaging in, and clearly, much of the work on access to care that we need to be aware of is happening through the auspices of Rick's office. So we've asked Rick to come today to really just give us an overview of their work and to allow you some time to engage with Rick and Nancy on what their research agenda is and how that might complement ours, might be an alternative to ours, so that we can really fashion our work going forward.

So, thank you both for coming again. Thanks for coming a little early, and we'll get started so that we can maximize our time with you.

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE) RESEARCH AGENDA IN MEDICAID AND CHIP

DR. KRONICK: Thanks so much, Diane. It's great to be here. Thank you for giving us the chance to talk with you this morning and thanks for accommodating the schedule change for which I apologize, but Nancy will be here to answer any of the questions that are left unanswered.

And a warning -- slight changes in slides from, I think, what was distributed, but very slight you'll see on the way through.

I'm going to go very quickly through a variety of activities of the Office of Health Policy, spend a bit more time on this first bullet, the Medicaid Access Project, which Diane and Lu asked us to discuss, and then just kind of very lightly over a variety of other activities of the office. I'm happy, of course, to answer any questions. And we work closely with MACPAC staff, and so there's ample opportunity for follow-up on this.

The Medicaid Access Project, though we're working on very closely with our colleagues in CMCS and with state Medicaid folks, has a variety of motivations, and one of the motivations comes from just the 1965 start of the program. The program is almost 50 years old.

And 50 years ago the statute says that state plans should be sufficient to list enough providers so that care and services are available under the plan. And 45 plus years later, the Federal Government has not been in the business of systematically trying to figure this out. And Cindy Mann and people at CMCS and the Secretary and my boss, Sherry Glied, all feel it's very important for the Federal Government to be monitoring access to care in Medicaid, both nationally and at the state level.

A related motivation comes from the NPRM that was issued last May in which CMS proposed Federal guidelines for states when they come in and say they want to cut payment rates, that they need to show something about access. And that is a state-generated process, but we think it will be useful to have some Federal view of what access to care looks like at the state level.

And then, a third and related motivation is 2014, 50 million more people coming to the program, and it's really important to have some way of trying to figure out whether these beneficiaries are getting access to care, to high quality care.

So, that's motivation.

On the approach, we are trying to develop a multidimensional -- or not develop, but really use a multidimensional approach. Access is not any one thing. Three mean dimensions that we're looking at -- one is utilization of services, one is beneficiaries' perceptions of access and barriers to care, and the third, provider participation.

On utilization, we have been assessing the ability of MSIS to provide information on utilization of services. Basic things like what fraction of beneficiaries have at least one office visit in the last 12 years or the fraction of beneficiaries with a dental visit, the ratio of emergency department visits to office visits, number of prescriptions filled.

There are, as I'm sure you're aware, a variety of limitations in this approach, not clear what the ideal level of utilization is. I mean, 99 percent for adults having office visits is probably not right, but 40 percent is probably not so good either.

MSIS data, as I know you're all aware, are often incomplete or not comparable across states, certainly have the problem of not having good encounter data for the many beneficiaries in managed care.

CMS, in their transformed MSIS process project, is working on trying to improve both the timeliness and the accuracy, but that is a work in progress, clearing time lags and getting complete data. We are, I should say, in early stages of this process. We've done a fair amount of work in evaluating data sources, and I'll discuss the process later. I'd say, kind of, MSIS seems possible but it is not clear what can be done on an across-state basis here.

On beneficiaries' perceptions of access to care and barriers to care, three main data sources that we are assessing -- the National Health Interview Survey, the Medical Expenditure Panel Survey and the BRFSS, Behavioral Risk Factor Surveillance System.

NHIS has the advantage of a much larger sample than MEPS. But even with NHIS, to get state-level estimates, you'd need to combine a few years of data. So it can be useful but won't provide an

annual look at what's happening, and even combined estimates are not available for all states.

MEPS has got some very useful questions for national-level analysis but isn't really appropriate at the state level.

And BRFSS is, in some ways, the most promising in that it's got very large state-level samples that allow annual estimates. On the other hand, they don't actually ask people whether they're enrolled in Medicaid. So they know whether people are insured. And you can look at all people below 100 percent of poverty, for example, many of whom -- with insurance -- many of whom are enrolled in Medicaid, and after 2014, even more of whom will be enrolled in Medicaid, but it's obviously got that limitation.

And then finally, on these three dimensions on provider participation, we are assessing both NAMCS, National Ambulatory Medical Care Survey conducted by NCHS, as well as a proprietary database that SK&A has created to look at the ability of these data sources to provide state-level, timely estimates of participation in Medicaid.

We're also doing a fair amount of work with MSIS, assessing the ability to do similar work with MSIS, using the NPI, the National Provider Identification number, which has been collected since 2008. It seems to be getting better over time, still has troubles with it, as well as doing work with the master file.

So on process here, we have a technical -- a TAP -- panel that will be meeting in June. I believe that MACPAC staff will be there. We are grateful for that.

We're expecting a report back from a contractor on the assessment of these various data sources in September as well as an internal report that we are working on.

And we are doing all this work in close collaboration with our CMCS colleagues and with Medicaid -- state Medicaid -- programs. We've had a number of conversations with NAMD, and we'll be continuing that.

Are there questions about the Access Project because then I'm going to go sort of very quickly

through another laundry list of things?

CHAIR ROWLAND: Right. Are there questions?

Denise.

COMMISSIONER HENNING: I just had one when you were going over the NPI being able to track physicians and the relationship of where they're practicing and that kind of thing. Since nurse practitioners and certified nurse midwives have NPIs, are you also tracking that?

DR. KRONICK: We would like to. We're kind of taking this in phases. And even the NPI for physicians is difficult, and so the first phase is trying to figure out kind of can this work for physicians, and then we will also look to mid-levels and see what we can get there.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: Regarding data sources, this is a question both for our group and you as well. There is a very robust and rich source of data about Medicaid that goes well beyond anything that we've been using, or it sounds like you've been using, from the Medicaid managed care plans. And -- which is one of the great benefits of putting people in managed care. I know from our system we can link everything -- pharmacy, radiology, lab, ambulatory hospitalization, cost, demographics.

So nobody seems to use the data from the plans. Now maybe some of the plans have proprietary information, but you're the government.

And certainly, I just think that the kind of issues that we talk about, and you're talking about with the data from these surveys, is not nearly as robust as what we could provide you.

DR. KRONICK: Yes.

COMMISSIONER GABOW: And yet, no one seems to look at that data set.

So maybe we both -- maybe both, we could and you could comment on that.

DR. KRONICK: Yes. It looks like Sara is trying to jump in.

COMMISSIONER ROSENBAUM: No, go ahead.

DR. KRONICK: I would say from your lips, yes. I mean, this is sort of the holy grail for people who are trying to understand what's going on in the Medicaid program, and a huge hole certainly at the Federal level and in some states at the state level. You know, increase -- I mean, the managed care plans are required to provide encounter-level data to states which are required to provided it to the Federal Government, but it has not happened well. And so, in the government, in the data that's available to the Federal Government, it is quite spotty at the state level about whether there's information about utilization and services within managed care plans.

CMS is working intensely with a number of states in a pilot project to try to improve this and the transformed MSIS project, and we have high hopes for that. But it --

COMMISSIONER GABOW: Why don't you just bypass both the Federal Government and the states and go to the plans? I mean, that's what I guess I don't understand.

CHAIR ROWLAND: Okay, David and then Sara.

VICE CHAIR SUNDWALL: Okay, Patty, I'm just interested in your comment because they list as a limitation, lack of managed care data. Is that because they haven't asked and you actually do have this kind of data, or is Denver Health unique?

You make it sound like a terrific resource for data, but I thought that -- I'd always assumed that one of the problems is we couldn't get Medicaid information out of managed care plans.

COMMISSIONER GABOW: Well, yes, Denver Health is unique. Now --

[Laughter.]

COMMISSIONER GABOW: But I mean, I guess I'd ask Richard and Donna. I mean, this data is there.

I mean, I think this subset of data that states ask for from us, and the way they ask for it, is not

necessarily reflecting the robustness of the data which could be provided.

VICE CHAIR SUNDWALL: Okay.

CHAIR ROWLAND: Richard or Donna, do you want --

COMMISSIONER CHAMBERS: Sure. Actually, maybe Mark could comment too. What I see is it's always tied to the money and the rate-setting at the state and the annual rates submission for plan-specific rates. The data is quite robust because you don't get paid if you don't submit the data, and so plans have incredible motivation as to provide high-level detail to the states.

I'm just surprised. I don't -- you know, in California, Mercer does the rates and they do the collection of the data, but I'm just surprised that it stops there because it is there. So I'm a little confused as to why it's so hard to get it.

I mean not saying you're not asking, but I'm just surprised states cannot provide that more easily.

And again, maybe Mark can comment since Mercer does rate-setting for 37 states and they see the data that plans -- so anyway, my comment. Maybe Donna can comment.

COMMISSIONER CHECKETT: [Off microphone.] I agree I want to hear Mark's comments.

COMMISSIONER HOYT: I would second what Richard said. I think in most of the states where we do rate-setting we've been doing it a lot of times for 10 years or more now, and fee-for-service is useless or inappropriate. And managed care data has taken a while to evolve, but I think in a lot of places it's in pretty good shape.

There is some hesitancy though, I think, on the part of some of the states to share out of a fear of some kind of exposure or breach of confidentiality or somehow the state being cast in a bad light, somehow through what's shared.

But the data for the most part, I think in the states where we've done the rate-setting, are pretty good, especially if you're trying to measure year visits or ED visits. Well, pharmacy data have always been

really good. So it kind of depends on what you're after and what you're going to do with it, but maybe the states are holding out on you.

DR. KRONICK: Well, I think this is a solvable problem. I'm not the right -- you know, the people at CMCS are intimately involved in working with the states and trying to improve this.

I think that 10 years ago the problem was much more that many states didn't have the data from the plans. I think now, as you are all saying, in many states the states have the data. It's not yet getting to the Federal Government in a uniform and useful way for the most part.

CMCS is working very hard on this, but support from you all in saying this needs to get done, obviously, is a good thing.

CHAIR ROWLAND: Sara, then --

COMMISSIONER HOYT: One more side comment, another difficulty you've got, the definition of encounters and all of that is totally appropriate to bring up, a lot of times wildly inconsistent from state to state. That's a massive headache if you're a managed care plan contracting in several states, that we just can't agree on how we're going to do this. That definitely affects comparability.

The second issue would be the way the rate cells are built:

Is kids care in with TANF? Is it broken up separately?

Are age and sex cohorts of the same, different?

Maternity, is that embedded in the TANF rate? Is there a separate supplemental payment?

I mean, you could just go on and on. That frustrates a lot of the data collection and comparisons as well.

COMMISSIONER ROSENBAUM: Forgive me if I'm being thick here or if I'm just not getting it.

DR. KRONICK: Just a country lawyer.

[Laughter.]

COMMISSIONER CHECKETT: That's what we all say about you, Sara.

COMMISSIONER ROSENBAUM: Well, yes, but you know, when you wander -- when you're a lawyer and you wander into data, you start getting a little nervous.

But I don't -- there's something I don't understand. I don't understand, given the vast amount of MUA HPSA data, why we don't come up with an entire approach to access measurement that essentially starts with the assumption that given the geographic distribution of the poor disproportionately into areas that are already designated as either MUAs or HPSAs. And, of course, the HPSA designation gives you medical, dental, mental. I mean full range.

Why we don't simply assume for the sake of 1902(a)(30) that Medicaid beneficiaries live in communities -- I also think the issue is a community issue, not a state issue -- live in communities that are medically underserved and that have a shortage of primary care a lot of times, either by virtue of the medical underservice designation or by an actual HPSA measurement, and use an evidence-based approach in regulatory guidance to the menu of interventions that have been taken with some success over many years to reducing shortages or access barriers, and have states provide descriptive information and some statistical information showing which of the menu of interventions they're using because I think -- you know, again, maybe it's me, but I have a feeling that we are so knotted up in trying to prove the obvious here, which is that poor people live in areas with inadequately health care systems and all kinds of consequences flow from that.

And since we have all these other data sources that tell us that, isn't there some way to simply use a certain set of working assumptions and spend the time on the remedies, not so much the measurement of the problem?

DR. KRONICK: That's certainly a very important point, and obviously, time needs to be spent on

remedies. I think, as you know both at the state level but also at the Federal level, for some people to be convinced that remedies are needed there needs to be some demonstration of the problem.

And yes, we know that there are -- that poor people live in underserved areas and that we don't have enough primary care in underserved areas, and that ought to be worked -- that needs to be worked on. But part, I think, of the ability to create change either by requirement or persuasion is some demonstration of that. You and I know that, but not everybody else is going to agree.

COMMISSIONER ROSENBAUM: I think Medicaid's future is in its ability to use its various levers to reduce medical underservice and to sort of right-size health care. And so, I see this as such a contentious process with so many limitations, of course, not because of you but just because of the data.

And we would still be left with a system that, by and large, operates at a state -- it depends on sort of state-based views, that really I care much more about what Missouri or California or Connecticut would be doing to move the levers in its local, rational delivery systems which are the MUA designations. That, to me, might be a more fruitful avenue for pursuit, and I think consistent with 1902(a)(30).

CHAIR ROWLAND: Okay, David, and then I'm going to let Rick go on since I know his time is --

VICE CHAIR SUNDWALL: Sara, just reminded me. I think this is an opportunity for simplification of this whole process or make it more uniform.

As I recall NAMD, when the Secretary published a rule last spring, there was push-back, to say, oh, my gosh, there they go again, more data requirements, more complexity of Medicaid for them to do what was expected in the rule she published. I believe -- am I not right -- that there was quite a bit of misgivings on the part of the collective voice of the Medicaid directors.

So understanding that that's the case, could we somehow simplify or coordinate or make this a process, using the assumptions that Sara has talked about?

As the former administrator of HRSA, I know how much good data there is. I know they're also working on redefining -- or, have they done that? Sara, what's the status of the redefinition of a HPSA and an MUA?

COMMISSIONER ROSENBAUM: Well, a negotiated rulemaking was going on for a couple years. The rulemaking basically finished its tasks. It's in HHS now.

And importantly are the conclusions that the rulemaking process produced, but much more important, I think, are the astounding amounts of data produced for that process by Bob Phillips and others. It was really sort of a brilliant and massive undertaking to try and update the way we measure these things and a lot of thought, over a year and a half, given to how do you know when you have an underresourced area.

And so, it seems to me this is just staring us in the face and we ought to be plumbing for all it's worth.

VICE CHAIR SUNDWALL: Thanks.

CHAIR ROWLAND: Okay.

DR. KRONICK: I agree with you completely, David. And kind of part of this effort is, at the Federal level, to create some simplicity to this, and we are working closely with Ed Salsberg and our colleagues at HRSA who developed all this wonderful data.

CHAIR ROWLAND: And we actually hope to have Ed at our next meeting because he was unable to come today, but let's let Rick finish.

DR. KRONICK: So then very quickly, a sort of once-over lightly on a variety of other activities, we are working on commissioning an evaluation of the Medicaid expansion. There's really a lot of work going on outside the Federal Government in this area -- Robert Wood Johnson and other foundations -- and we're trying to coordinate and not duplicate the work that's being done on the outside. But we have a

design contract underway and expect to be issuing a solicitation for a broader evaluation likely focusing on vulnerable populations as a particular interest of HHS.

We are working very closely with our colleagues at CMCS and a variety of state Medicaid programs on developing methods for MAGI conversion, for converting net income/gross income standards to MAGI standards for 2014, and for figuring out some way of computing what the proportion of old and new eligibles should be, or are, in each state without having the applicants go through a shadow eligibility system. This is very much an in-the-weeds project --

CHAIR ROWLAND: Critical.

DR. KRONICK: -- but one that's taking a tremendous amount of energy.

Some of you are smiling. I don't know why you're smiling. It's because you're not working on it.

[Laughter.]

CHAIR ROWLAND: But we're glad you are.

DR. KRONICK: Yes, thank you.

We are having a contract to assess or come up with options for DSH payments. The Affordable Care Act, as you know, calls for changes in allocations of DSH, and we have a contract to analyze a variety of hospital and state-level data and come up with some options for how to do that and what the implications would be of various alternatives.

We're doing some work on the primary care payment increase that will start in 2013, both getting baseline estimates of utilization and spending as well as assessing options for how to evaluate the effects of these increases on physician participation and on utilization -- clearly, very closely tied with the first Access project that I discussed.

We have a contract that will finish quite soon on trends in Medicaid and CHIP managed care, in part, looking at what states have been doing to monitor the adequacy of networks, trying to get information

about changes in the size of networks and the composition of Medicaid managed care. The Kaiser Family Foundation put out a report six months ago, and we're building on that as well. The sort of newer part to this, assessing rates have increased in Medicaid managed care over the last decade in about 20 states throughout the nation.

These last couple projects I think I discussed probably two years ago, which they were just in motion then. Results will be out quite soon on the Medicaid managed care.

The Medicaid Atlas of Healthcare -- we should have a functioning web site in the fall that provides information on state and sub-state variations of Medicaid utilization spending, using MAX data. It's got three sections. The release in the fall will have three sections -- one on acute care, one on long-term care and one on mental health, and then somewhat later in a second phase of this project, analysis of care for people with diabetes.

We are focusing, as I had done earlier in work that I did when I was back in San Diego, on the disabled receiving cash assistance -- somewhat more comparable across states, less of the managed care problem that we discussed. And this will be, I think, a quite exciting project when it comes to fruition.

And then we are doing two congressionally mandated evaluations, one of the CHIPRA program. We submitted a report, an interim report, to Congress last December and have a much more fulsome report scheduled for December 2013. This evaluation in statute looks exactly like the last CHIPRA evaluation. In practice, because the world has changed, we are focusing much more on the implications of CHIPRA for 2014 and how the program has changed and will likely continue to change.

And then, finally, we are doing a congressionally mandated evaluation of Express Lane eligibility, looking at sort of what's happened in the handful of states that have implemented Express Lane, but, again, trying to learn lessons for how we can make -- we, states -- enrollment really work in 2014 and beyond, and here the first report is due in September of 2012.

So that is, I think, a very quick overview. I wanted to give you time for questions rather than spending time kind of talking at you.

CHAIR ROWLAND: Thank you, Rick.

COMMISSIONER MOORE: Kind of a technical smaller question related to your managed care study. I know over the years ASPE has done a lot of work around risk adjustment, and this Commission has been very interested in the disabled Medicaid non-dual population. And I wonder the extent you've looked at risk adjustment in that managed care study or whether you are doing work around that as we move towards exchanges and all --

DR. KRONICK: We have gathered some basic information about what states are doing in terms of how they're paying -- whether they're using diagnostic adjusted payment, and so we will be reporting on that. We're not doing development work around Medicaid-specific risk adjustment systems. We're working closely with our colleagues in CCIIO on the development of a risk adjustment system that will work for the exchanges, and there will, you know, likely be some spillover of that to Medicaid, but that's, you know, kind of to be determined.

COMMISSIONER MOORE: You're not engaged, as you have been in the past, in a lot of specific risk assessment research?

DR. KRONICK: No.

COMMISSIONER MOORE: Okay.

CHAIR ROWLAND: Sharon, did you have a comment?

COMMISSIONER CARTE: No.

COMMISSIONER CHECKETT: Rick, one of the things I've been so fascinated in is the MAGI definition and really interested -- will be very interested in your findings on how to streamline eligibility, as I'm sure you all will. Just give me your thoughts on what do we know now about the population in terms

of how many of the families are actually filing income tax. How are we going to deal with that when so many have been, you know, kind of employed off the books or marginally employed? I'm just not familiar will how that population is working with our tax system right now. Thank you.

DR. KRONICK: Well, we are likely to -- I mean, as you know, Medicaid works on -- eligibility works on current income in any case, so even for people who are filing taxes, there will still be a continued need to be gathering information on current income sources, and so I think the need to do that exists today will still be there in 2014 regardless of MAGI or not. You know, it will be in many ways simpler because without having to deal with all the disregards that are built into many Medicaid eligibility determinations now, the information that's needed to figure out or to proxy what a person's MAGI would be is less complex than the information that's needed to figure out now is somebody eligible, is their net income making them eligible for Medicaid.

But I think that, you know, there is maybe in some folks' minds the thought that, Ah, the people who are filing taxes, you know, that is all the information that would be needed to determine Medicaid eligibility. You'd still need to know, you know, is their income expected to be the same or not, and if not, have information on it.

COMMISSIONER GABOW: My grandfather always used to say to me, my Italian grandfather, "Rome wasn't built in a day, my girl." So I know that we have to start somewhere, but I would want to make two comments about access, one of which relates to Judy's comment about risk adjustment. And maybe Richard and Donna can weigh in on this.

We just recently tiered all 130,000 users of our community health centers, and about 70,000 of them were basically healthy, and probably the only access and utilization they needed was preventive care -- their mammograms, their shots. About 1,200 of them were catastrophes, medically, and they generated $56 million in charges in a year. And what they needed was a very different model of care from what the visit

was like to between-visit care.

So understanding what appropriate access is I think has to go with some sort of risk stratification because what we do now is we report, you know, flu shots and things like that. But if you're in -- that's great if you're in the bottom tier, but if you're in that top tier, it's a very different model.

So I realize that, you know, we have to start with an office visit, but we should really have clarity both in what we communicate to people, that this is really not going to be the end game.

The second comment about access is while everybody always talks about primary care, that actually, by and large, is in my opinion not the problem for most Medicaid patients. The problem is specialty care. So I think somewhere in all of this discussion the ability to understand both access to specialists and then the utilization of certain things, like how often do they get hernia repairs, cataract surgery, cardiac caths, transplant, joint replacement, cancer treatment, these are things that I know from our experience as being one of the few providers of specialty care for Medicaid and the uninsured are what people need but have no access to.

So I think that as we look at utilization and access and adequacy, both of those things, stratifying what is needed by their actual clinical needs and then thinking about not just primary care but specialty care is going to be really important. And I don't know if you have any thoughts about is this possible in life as we know it or not.

DR. KRONICK: You know, very good points, and I would say it's somewhat possible. The Medicaid Atlas of Health Care project that I described has a Phase 2 -- it won't be there in September, but it's coming -- trying to describe the care for people with diabetes and what sorts of care are they getting, and that is, you know, very much in the direction of what you're suggesting. It will not be as fulsome or complete as any of us would like. You know, as we've discussed, it's actually entirely based on fee-for-service data, which for people with disabilities is less of a limitation, but still so, particularly in

Colorado and some other states.

So we're, you know, trying to move in this direction, more slowly than any of us would like, I think.

COMMISSIONER COHEN: My question is not going to be that quick, and I'm sure the answer is not either, but I'll try and make it as short as possible, and say whatever you can before you have to go. A very open-ended question. You know, we in the Commission are struggling all the time, anybody in this health care field is, which is that, you know, we're in a fairly crisis situation on about 99 dimensions, and we all know that change needs to come in a whole variety of areas, and nobody is really entirely sure what that change should look like, and everyone is scared of moving too fast or too far and making a huge mistake, and at the same time recognizing a huge imperative for change. And, oh, right, then on top of that, with Medicaid at least, horrible sort of really, you know, poor lagged data.

So I guess my question is kind of -- it goes to sort of like the process of research and evaluation around these programs and populations that are served by public health care programs. How can we, or can we, or have we, sort of accelerate the kind of like rapid feedback processes that can allow us to really act on program weaknesses that are identified in research in a timely fashion? And that is just becoming, I think, a huger and huger imperative every single day, and maybe just some comments on how can we or have we or can we.

DR. KRONICK: No magic bullet, not surprising. I think the answer is working at it. You know, as I mentioned, CMS is working closely with a large handful of states on transformed MSIS data to try to improve the timeliness and quality of those data. We are investigating a variety of data sources, most of them non-federal because federal, it's hard to kind of do quickly. But looking at, you know, Gallup and at various data aggregators that gather data from physicians and hospitals and send them on to insurance companies and have them pretty close to real time.

So, you know, part of it is recognizing the problem and working one by one to try to figure out the

solution. You know, probably the prior step is being able to clearly anticipate what is important to know, and that I think is always a challenge. You know, given how hard it is to know anything, you've got to figure out 18 months, two years in advance, what it is we're going to want to know to try to make sure then that the data sources are there for when you need it to know that. And we're working at doing that, as I'm sure you are here as well.

CHAIR ROWLAND: Okay. Rick, I think it is, unfortunately, time for you to go, but, Nancy, if you could stay for a few more minutes, that would be great.

DR. KRONICK: Thank you very much.

CHAIR ROWLAND: Thank you very much for coming, and keep working on the data and the information so that we have something to share.

DR. KRONICK: Likewise, [off microphone] great work with MACStats and such.

CHAIR ROWLAND: Questions for Nancy?

COMMISSIONER HENNING: I guess my main question is how much of this work that's being done, not only by your office but also in the states, are kind of at this moment stuck in neutral until we hear from the Supreme Court and their decision on the ACA.

MS. DE LEW: Many of us in this room and in this town are waiting for that, so I don't think I have anything to add, meaning we are working every day, getting the work done that we need to get done. We're not holding back waiting to hear what might be coming, but it's on everybody's mind what's coming.

COMMISSIONER HENNING: Sara, can you tell us?

COMMISSIONER ROSENBAUM: I was just on the phone with all of them yesterday.

[Laughter.]

COMMISSIONER ROSENBAUM: I promised not to divulge it.

I think we're going to see it when we see it.

CHAIR ROWLAND: But from Rick's comments and, Nancy, a lot of what you're doing is about the basic Medicaid program that we have today and about trying to get better information and better data around how that program works and around how access to care functions there. So I think this is work that builds on a base that started in 1965 and is unlikely to be affected in many parts by any of the rulings other than your work on the eligibility issues that come out of the Supreme Court.

Could you talk a little bit -- I'm interested in following up on Sara's comment and I know David's concern about the recalculation of medical under-service areas and how that really will affect some of the work that you're trying to do. Are you doing any mapping of provider participation in Medicaid against those areas? Or what's the work in that area?

MS. DE LEW: Right. So we have an enormous number of data sets at our fingertips, and we're trying to figure out how do we put some of those together. You know, we have Medicare claims, we have Medicaid claims; we have the National Provider Identifier which Rick talked about, the NPI. So we're looking to try to link that information and to look at practice patterns around the country. We're at the very early stages of that work.

You know, as Rick noted, we're trying to make sure that the underlying data is in good enough shape to do that analysis, so we've been doing a lot of work looking at the NPI, for example. Does it map to a physician that we can find someplace else in our records?

So we are definitely looking at the ability to do more mapping. The Medicaid Atlas project Rick talked about is our first foray, if you will, into mapping, and we hope to be doing more work along those lines as we get more work on the underlying data.

COMMISSIONER ROSENBAUM: Yeah, along the same line, I'm sitting here wondering whether it wouldn't be feasible to pick a dozen markets of varying kinds, 20 -- I don't know what number you'd have to pick -- but markets that would be considered by objective measures relatively well resourced.

For example, I think about Denver Health because it's a large network of community health centers because of Denver Health, because you sort of have ideal conditions. You have primary care entry. You have a very large system that has a total affiliation with the primary care system so that you have objectively reasonable availability of specialty care if needed, and then picked other markets where those kinds of conditions don't exist. And from those different kinds of markets, compare use, access, outcome, and then really break down the markets to figure out what kinds of interventions, some of which may have been state-generated, a state's Medicaid managed care policies, the infusion of 330 grants, capitalization, heavy capitalization of a public system, I mean, because it's way more than just what the state has done, although the state's Medicaid behavior is probably associated with other things. For example, the Medicaid behavior would probably be associated with whether a public system is able to raise the kind of capital it needs because of the availability of payment.

But if you chose a bunch of markets and compared access, use, outcome among Medicaid beneficiaries in highly resourced and poorly resourced markets, would that give us some way of knowing what the suite of possible interventions is that we would want to see pursued in an access measure? In other words, rather than trying to just divine it from abstract data or data in large sort of free-standing data sets, construct a bunch of markets or study a bunch of markets based on what's actually out there that an expert panel and objective data would tell you are either well resourced or underresourced, and then look at all of the Medicaid indicators in those markets. Maybe that would be a way of telling us in a more grounded fashion, you know, what we ought to be looking for, what combination of policies the Commission ought to be promoting that gets us better outcomes.

I'm just afraid with the -- you know, this issue was such a real and solid issue as opposed to something where we're looking at large expenditure patterns or enrollment patterns, this is such a local issue that I can't really think of another way except some original structuring of markets and studying the markets

to, you know -- I mean, I know that the Center for Studying Health Systems Change obviously has structured its study markets, and whether those could be used than overlay state Medicaid data on to see, you know, how Medicaid programs differ depending on whether they're lying on top of a well-resourced market or not.

MS. DE LEW: So I think you raise some interesting questions. I think we could go at it either way, which is what you're talking about, look at resources and look at well resourced and not so well resourced. You could line that up with what we're hoping to look at in terms of the underlying data and see do the places where access seems to be better and worse match up with what you're talking about or not match up and why.

COMMISSIONER GABOW: Well, to Sara's point, I think the markets where you would look are all -- that data may be available already from the Commonwealth's state report card and from their most recent hospital referral regions. So it's sort of looking at it -- you could define the markets by the outcomes, and it's very clear that there's huge variability, and it's sort of variable where we knew it was going to be variable, I think at least from the state perspective. So you already know where to look, I think, and then what you could do, to your point, is dig deeper and do why are these so radically different where you're talking about six- to ten-fold difference in outcomes. So I think you have the ends of the bell-shaped curve.

COMMISSIONER ROSENBAUM: Yeah, I mean, what got me thinking about it was if we took D.C. and we took -- we don't have 130,000 health center patients, I don't think here, but the numbers are high. But our ratios here would look nothing like 130,000, 70,000, you know, low users and 1,200 catastrophes. The ratio probably would be much more than 1 percent. It would probably be 3 or 4 percent because we don't have a well-organized health care system here. We have pieces, but they just don't function well, and my guess is, though, there are other markets that would look more like Denver

where things function reasonably well. And I understand that it is -- you know, you're grouping sort of lots of different kinds of people and lots of different kinds of services together, but it seems to me you could refine what you're looking for and structure markets and look at Medicaid agencies' experiences depending on the kinds of markets they're working in.

COMMISSIONER HOYT: I'm looking at the slide on trends in Medicaid managed care, just that little sub-bullet on provider network adequacy, I think touching on some of the same things we were talking about. What trends are you seeing or what are you looking at? And I was wondering specifically, do you talk to some of the larger national managed care plans that wrestle with this issue, either in an urban area or a rural area? How do they decide whether their network is adequate to pursue business in that area? And maybe sort of in a related vein the RFPs that states use, how are they changing over time to try and get their hands around establishing network adequacy?

MS. DE LEW: So we don't have the final report back from that contract yet to be able to answer your question in the detail that you've raised it, but network adequacy is obviously a key consideration for us at the federal level in a number of different programs, this being one. I don't have a lot of detail to answer you with yet, but we will have more information, and we'll be able to share that with you all.

CHAIR ROWLAND: Who is the contractor working on that study?

MS. DE LEW: Urban Institute.

COMMISSIONER CHECKETT: Looking at the primary care bump that will start in 2014, do you know where the states are on average right now as a percent of Medicare?

MS. DE LEW: We are looking at that. We're doing analytic work to figure out how to frame that study, so I don't have an answer for you right now.

COMMISSIONER CHECKETT: Thank you.

CHAIR ROWLAND: One other question. I know one of our areas that we are to examine and

look at in greater detail is the CHIP program and how the CHIP program is working and what some of the future issues are facing that program. Could you go a little more into the detail of what will be in your CHIPRA report since we also are bound by our statutory authority to review all reports to Congress?

MS. DE LEW: Right. So the CHIPRA 10-state evaluation is looking at -- they're just doing case studies now, so we're in a number of states talking to a number of folks in those states. We don't have case study reports back yet. We're going to be hoping -- not hoping. We're going to be having additional material. The December 2011 report that we sent to the Congress was a very high level overview of what we plan to do and looking at the early data from states on CHIP.

So I'm not sure, Diane, how much more I can tell you in terms of the case studies because that's where we are right now, but we're hoping to get a better sense from state perspectives of what they think the challenges are with CHIP and what we ought to be thinking about as we think about 2015 and does CHIP continue the way we know it now or some change is contemplated for CHIP.

CHAIR ROWLAND: And there you're really looking at 10 states, not at all 50, because one of the things that we struggle with is as we try to figure out analytically what to look at, do we always need data from all 50 states, or are there ways in which we can do more targeted analysis and evaluation. And so you've obviously for this one decided to look at 10 states and not to try and evaluate 50.

MS. DE LEW: So we're doing both. We're doing a 10-state case study, looking at 10 states in a case study and a more deep dive with those states. We're also doing a national survey of CHIP program administrators, so we're also going to collect data from all 50 states. So we'll have both pieces -- a deeper dive and a higher level look, if you will, at all 50 states.

CHAIR ROWLAND: Okay. And when is that due to Congress?

MS. DE LEW: December 2013.

CHAIR ROWLAND: Okay.

COMMISSIONER ROGERS: What are the ten states that you chose?

MS. DE LEW: I was afraid you were going to ask me that question. I don't have them with me here. We can get them for you.

COMMISSIONER ROGERS: Okay. I just wondered -- I mean, did you --

CHAIR ROWLAND: She wants to know if Texas is one of them.

COMMISSIONER ROGERS: Exactly.

[Laughter.]

MS. DE LEW: Ohio. I'm thinking, Where are we sending people on site visits. Texas, Ohio, New York. I don't have them all on the top of my head.

COMMISSIONER ROGERS: That's okay. Thank you.

How did you choose the states?

MS. DE LEW: We wanted a geographic spread across the country, so we wanted them across the nation. We also wanted to look at CHIP programs that were separate, meaning running a CHIP program as well as CHIP programs that were combined with Medicaid. So we were looking to choose 10 states that vary across a number of dimensions, geography being one and the type of program being another.

COMMISSIONER ROGERS: Did you all think of demographics like, you know, some states have a higher rate of minority population than others?

MS. DE LEW: Right, so that's part of our geographic spread across the country, yes.

COMMISSIONER ROGERS: Okay.

CHAIR ROWLAND: Okay. Other questions for Nancy?

COMMISSIONER WALDREN: I don't know, maybe it's a question, but as I look at all the different evaluations --

CHAIR ROWLAND: Do you have your mic on?

COMMISSIONER WALDREN: I do have it on. I'm just not close enough to it. So as you look at all the different evaluations -- and we talked about some of the issues. We talked about data being an issue. But, you know, is there like a top-ten hit list or a most wanted list of things that you need as you're looking at these different evaluations? For example, we talked about in access the severity scoring thing became an issue. Is that something that is kind of a cross? All I'm trying to think about is there are a couple of things that we as a Commission should try to think about that would help evaluations across different Medicaid types of programs, what's challenging you guys.

MS. DE LEW: We have a lot of challenges. No shortage of challenges. I think across -- there's always -- I'd say one is we always want to know more about specific states than we can get with the national data that we've got available. So it's the balance that we're striking with the CHIP evaluation going in and talking to people. We're doing that with the ELE study as well, going into states, doing case studies with states. In many of our evaluations we try to do case studies because there are contextual factors that you're not going to be able to get from a 50-state survey.

So I think the significant challenge that we face, as does anyone else doing this kind of work, is trying to figure out what is different about specific states and why they get the results they do and what's similar across them. So that's a very high level response to your question.

COMMISSIONER RILEY: Just a quick question. I am slow. Back to the point of the two-year bump in primary care, I am intrigued by that because I think it's so limited in terms of -- it's such a contrivance. Will we know how much -- how much will we know from your review of what states did? Because it may be an opportunity for states to do some creative demonstrations over a two-year period. Will we know what they did for rates or just how much they raise them?

MS. DE LEW: So right now we are planning our research agenda for the coming year. That's one of the projects that we're planning, so we don't have a lot of specificity around that project yet. We're

going to -- we're looking at bonus payments in the Medicare program where we've got a longer history of physician payment bonuses. The bonus there runs until 2015. We're going to try to figure out what can we know from that experience and how might it apply to the Medicaid program. That's obviously, you know, a potential reach, but we're trying to look at what bonus payments do we have, what do we know about how many providers receive those bonuses, how much money did they get. You know, some of the bonus funds may be low. Is that really going to affect a provider's decision about where to locate?

We're in the early -- right now we're thinking of looking at developing a strategy for the 2013 and 2014 Medicaid. Those funds are obviously not being paid yet so we can't look at any claims data right now. We are on the Medicare side going to look at actual claims data and look at how those funds were used as a way to help us think about a Medicaid strategy.

CHAIR ROWLAND: What are you doing about payments within managed care plans?

MS. DE LEW: So we have to think about what our plan is there. We don't have one yet, but we know that that's --

CHAIR ROWLAND: A big stumbling block.

MS. DE LEW: Say again?

CHAIR ROWLAND: It's a big obstacle to get over.

MS. DE LEW: Yes.

CHAIR ROWLAND: Any other comments for Nancy?

[No response.]

CHAIR ROWLAND: Well, I want to thank you, Nancy, for filling in so ably with Rick's departure, and we thank both you and Rick for coming and sharing with us your agenda, your issues. I think it's been heartening to some of the members of the Commission to know that even within the Federal Government you struggle with the same kind of data problems that we're trying to overcome. I think

Patty and others would like obviously us to get more real-time data from real plans on the ground, but I know in much of the work you're doing you're also struggling with national surveys and how to make national surveys provide overall answers.

I haven't heard any discussion of doing a current Medicaid beneficiary survey equivalent to the current Medicare beneficiary survey, but we would be pleased to hear any of the future activities that you all are planning that might, in fact, give us other more timely sources of data.

MS. DE LEW: So on that point, we have talked internally about that very question. One of the results we hope to get from our Medicaid access study that Rick started talking about -- we have a contractor, as he noted. NORC is working on that. One of the things we've asked them to do is to give us recommendations in terms of -- you know, he talked about the limitations of the current national surveys. What might we want to think about in changing some of those surveys? You know, an obvious recommendation might be for BRFSS, for example, add Medicaid, you know, does the person receive Medicaid or not. So we're looking to see what can we do to our existing surveys to make them more useful. We would welcome your suggestions along those lines as well.

As we noted earlier, we have a TAP panel coming up on that project where we are inviting a number of people to come in and to help us think about how to improve our ability to measure access. So we thank you very much for the suggestions today.

CHAIR ROWLAND: Thank you very much, and now we'll take a brief 10-minute break and reconvene to talk with Melanie Bella about the work in her office on dual eligibles. But thank you, Nancy, and extend our thanks again to Rick.

[Recess.]

CHAIR ROWLAND: Commissioners, if you could return to your places.

We would like to welcome Melanie Bella, the Director of the Medicare and Medicaid Coordination

Office at CMS, to join us today. I think there is no doubt among anyone in this room that the issue of dual eligible beneficiaries for Medicare and Medicaid and how to better manage and coordinate their care and whether there are ways in which that coordination can yield savings to both the Federal Government, to the States, and potentially to the beneficiaries themselves has been at the top of many agendas. We know that there's an ambitious effort going on in the Department under Melanie's direction and we're very pleased to have her here today to share with us where they are to date and where they hope to be going very soon and how that will affect the care and the cost for these populations that are such high-need and high-cost populations to both Medicare and Medicaid.

So welcome, Melanie, and we will entertain your presentation and then questions.

UPDATE ON MEDICARE-MEDICAID COORDINATION OFFICE ACTIVITIES

MS. BELLA: Great. Thank you. It's -- I think I was here in October, right after we got things started, so it's nice to be back. It's nice to be in a Medicaid-friendly crowd, I'll say that.

I am going to -- just going to run through -- give you an update on where we are, probably with a little more emphasis on the financial alignment demonstrations, as I'm sure those are of interest to folks, but leave a fair amount of time for questions, if that works.

So as you all know, this is an office created by the Affordable Care Act. We're really focused on improving access, improving coordination, looking for innovative care models tailored to important sub-populations because this is not a one-size-fits-all approach group that we're talking about, and really trying to root out misalignments across the system.

We have three areas of work. These remain the same, but we certainly have had some developments in each of these areas that we can talk a little bit about today. The first is program alignment. The second is data and analytics. And the third is models and demonstrations.

So on the program alignment front, this is a group that is tasked with looking for everyplace that

Medicaid and Medicare do not work well together, and that can be driven by administrative policy that CMS has done. It can be in regs. It could be in statute. And we published in the Federal Register a notice for comment in May of 2011. We received over 100 comments, including from some beneficiaries themselves, so we were very pleased with that, giving us comment on how we should think about prioritizing some of these areas, and that will guide our work as we develop a regulatory and a statutory agenda for going after some of these misalignments.

The good thing is, most of the problems are not in statute, so they can be fixed either through sub-regulatory or regulatory action, which is a good thing. Of course, some of the really important stuff is in statute, so we will have to figure that out as we go.

We are required to submit a report to Congress annually. We submitted our 2011 report, and the link to the report is at the end on the slides, if people haven't seen it. Essentially, we gave an update on the Office and we did indicate two areas that we would like to explore for the future that would require future statutory action, one of those areas being PACE. So there's a lot of interest in looking for some flexibility in areas around PACE for lowering the age, giving some more flexibility around alternative settings and the multi-disciplinary teams, and a couple of areas.

And then the other issue that would require statutory action is streamlining appeals. There are some things we can do regulatorily, but a large part of it will require statutory change.

The additional work of the program alignment group now is really going out on the road, holding regional listening sessions to start to tackle certain problems. So, for example, home health is a tremendous problem with what happens with the disconnect between the two programs. So we had in Boston a listening session just focused on that issue with providers and States and beneficiaries and their representatives. I think it helped us solidify some things that we could take action on.

Another example is the Office is, in conjunction with the Medicaid or Medicare -- sometimes both

sides of the house in CMS -- issuing policy guidance. So we issued an informational bulletin about balance billing. Believe it or not, there is still a tremendous amount of balance billing going on for beneficiaries, and so we use Medicare to blanket the providers and Medicaid to get the word out to others. It's the number one thing that we get questions about in our office and the number one piece of information that comes to our website. So it's a problem and we're excited to have launched some aggressive action in that area.

The next area is data. I think when I was here the first time, I probably said to you that we're getting close to that goal of actually having some data that says CMS as the source, and we are. The integrated data set is there and we will be able to continue adding years to get more recent data from the integrated Medicaid and Medicare data set.

Where we spent the most attention over the past year, though, is in getting Medicare data to States for care coordination purposes, and this is an update on the slide that just tells you there are 22 States that have either received or are in process of receiving Parts A and B data and 20 States that have received or are in process of receiving Part D data. And, really, you would think it would be so simple and it was not so simple. And what's exciting now is we're actually working with the States so that they can have permission to allow downstream users to actually also be able to have access to those data for care coordination purposes. So, finally, people who are really interacting with the beneficiaries, within the appropriate privacy and confidentiality provisions, will have access to those data to help improve the care coordination efforts.

We also, soon -- that is my favorite CMS word -- meaning here might be early May, which we are almost in early May, will be publicly releasing and posting State profiles. So these will be profiles of Medicaid and Medicare, so dual eligible spending and utilization and programmatic features by States. And so I'd say the greatest thing I would caution is this is not meant to be a State-by-State comparison because

certainly every State has so many differences in terms of eligibility and service package and all of those things. But it is meant to help the general public and the States themselves have a sense of what the total combined spend has been, what some of the utilization patterns have been. Again, you will see there will be some things that are limited, for example, States that are heavy managed care, because we won't have the encounter data in there. But I think it's a good first step to getting information out there for looking at a combined picture of Medicaid and Medicare, and so keep an eye out for that in the next few weeks.

Then the next major area is with the demonstrations that we do in partnership with the Center for Medicare and Medicaid Innovation. So we started by launching an initiative to invite States to apply for design funding that would support the development of a fully integrated proposal. Fifteen States were chosen. Subsequent to that time, we realized there is tremendous interest in financial misalignment between the two payers and so we released two demonstration models, a capitated model and a managed fee-for-service model, and we opened those up to all States who were interested in pursuing one or both of those models.

We received letters of intent from 38 States plus the District of Columbia, and I'll give you a little bit of an update on where we are with those States. But what's most important, I think, is to ground everyone in what we're trying to do with this financial alignment initiative, which really is -- first and foremost, it's about the beneficiary and it's about having person-centered models that promote coordination and the person-centered models that reflect the differences of the sub-populations of the total group of dual eligibles.

We're trying to develop a more easily navigable -- we may have made that word up, but I think you'll all appreciate the need for it -- a simplified system. We want to make sure beneficiaries retain access, but more importantly, have enhanced access. Today's system is not working well. So protecting or preserving the status quo is actually not a good beneficiary protection. I would argue we're doing a terrible

disservice if we were to try to keep things the way that they are today, and so we really need to look for programs that are going to improve access. But again, these programs that we're developing are going to provide extra benefits that people aren't receiving today.

The financial alignment initiative will have to have very robust network adequacy standards for both Medicaid and Medicare. So I know there's -- no one seems to be quite happy with us, that the Medicare folks think we're making it too Medicaid and the Medicaid folks think we're making it too Medicare. But when it comes to things like this, we will have the best of both and then some because these are important beneficiary protections to maintain.

The second-to-last bullet, it's all about accountability. That's also what these financial alignment demonstrations are intended to foster.

And then we will be looking at data across the board, access, outcomes, beneficiary experience. We would do this anyway, but as you all know, the Innovation Center is really looking at -- has the authority to do demonstrations that reduce cost and either improve or do not harm quality, and so we can only move forward each year of the demonstration by making sure we're keeping track of the impact on both quality and cost.

So I mentioned that we had letters of intent from 39 States. Right now, we are working with 28 of those States, so 11 States have chosen not to pursue one of the models at this time, and we generally work with those States to provide other types of technical assistance. It just isn't the right fit for them right now. So we have 28 States. Nineteen of them are pursuing the capitated model. Six are looking at the managed fee-for-service model. Three States are looking at both models.

We require as part of our process that States publicly post their proposal for 30 days. Stakeholder engagement is non-negotiable for us in this process. And so the first step for the State is to publicly post the proposal. As of last night, we had 20. As of this morning, we have 22 States that have publicly

posted their proposals. So the two missing from the list on your slides are Iowa and Hawaii. So that means we have six to go and we anticipate getting those in the next week or so because the States submit -- I'm sorry -- publicly post their proposals for 30 days. Then they submit them to CMS. And all proposals must be submitted to CMS by May 31.

And then, again, as part of the stakeholder engagement process, CMS will publicly post the proposal for 30 days and we will take public comment and work with the States on the comments that we receive to see how they may shape the proposal.

I have to say, this has been one of the most, I think, rewarding parts of this process. The first State that did this is Massachusetts. Massachusetts got over 180 written comments and made some pretty significant revisions to the proposals based on the stakeholder feedback it received. CMS, we received somewhere in the ballpark of 20 comments, and I think that's a direct reflection of the fact, how much the State incorporated the feedback.

I would say the State of Ohio, when Ohio put its proposal out, lots of resistance. I'll make a very long story short and just say the day after Ohio posted its proposal, AARP came out in support of the proposal, and I think, again, that's in large part the way the State incorporated feedback to try to align its regions with the AAAs and really take that into account. And so that's very positive from our perspective, how this is working.

So three States have actually submitted their proposals. One of those States, Massachusetts, has gone through the CMS 30-day public comment period, obviously, since I told you how many comments we received. And the next step in the process is then we have standards and conditions that we use to assess each proposal before we move into the Memorandum of Understanding development phase. And so that's where we are with those States, looking at the standards and conditions, and with Massachusetts, beginning to hammer out the terms of how we're really going to operationalize this between the State and

the Federal Government.

So just a quick recap of the timing. Right now, we're in the spring to summer, so it's the demonstration proposal development. This summer to the fall is the development and approval of a Memorandum of Understanding. We have lined this up -- again, if you think about the perspective of a beneficiary -- we've lined this up with the open enrollment period in Medicare because they all get information, and arguably bombarded with information during that period of time, and so we thought to try to minimize confusion, we might try to line up with that process.

So, really, when you see some of our deadlines, it's because we're working on this annual cycle and we have to work backwards from that. And so working backwards from October, then, the things that need to happen between the MOU development and the October notices are contracts and readiness reviews and all of the things that are going to give us assurance that on January 1, it's okay for beneficiaries to begin receiving services in these new programs.

I should also note, though, we have given States flexibility to request a later implementation date if they would like. So we have several States, actually more States at this point, requesting a 2014 implementation date rather than a 2013 implementation date, and we think that's smart for a whole bunch of reasons. It balances things out and States are -- some States have been further along than others. And so those that need more time to develop, we're pleased to see that there's flexibility to have a second implementation round of States, if you will.

We have an Integrated Care Resource Center. This Resource Center, we do in partnership with Cindy Mann's shop at CMS, and this Resource Center is really focused on two areas. One is duals and the second is the Medicaid health homes. And so we have a contractor that is there to be of support to States to help them in anything and everything they would need in this regard, whether it's working on State plan amendments for the health home, whether it's working on data integration for the duals, looking at contract

language and best practices. So it's a nice resource for us to be able to augment the CMS resources.

I'm very excited to say, recently, we launched not a State initiative but one focused on beneficiaries in nursing homes. Again, if we talk about misalignment, this is kind of our sweet spot, and this churn that happens between nursing homes and hospitals, it's been a high priority for us. And so we have a funding opportunity announcement out on the street that looks to partner or contract with care entities that would go on site and provide clinical support for all the things that could be better managed on site -- urinary tract infections, pressure ulcers, dehydration, all the things that are preventable and avoidable. And so these entities are expected to partner with nursing facilities, but we will not be directly contracting with nursing facilities.

The potential for every looking like there was an incentive for the nursing facility operator to keep someone on site and not send them to the hospital was a real problem, and so we do expect, though, the entities to come to us with nursing facility partners and also to come with a letter of support from the State Medicaid agency and the State survey and cert agency so that we're sure that all parties are aligned in this initiative.

So key dates for this is any entity interested in applying must let us know by the end of this month, and then the demonstration proposals are due June 14.

We had a call, I think, last week. We had over 1,800 people, entities, something on this call. So I don't even begin to think that nearly 1,800 will be interested or qualified to apply, but clearly, this is an area where it just feels like a win-win-win for everyone involved, so we're really excited about that.

This just gives you some links to various things. I might call out a couple things. In the financial alignment headers there, CMS has released several -- a couple of key documents, guidance around the financial alignment demonstrations, in particular the capitated model. And if you haven't looked at them and you're interested in reading some really technical weedy stuff about Medicare solvency and Part D and

network requirements, it starts to lay out how CMS is thinking about the parameters for the demonstration and how we would work with States in the monitoring and the actual selection of the plans.

So that's sort of an overview of what we've been up to and I look forward to your questions.

CHAIR ROWLAND: Melanie, could you comment briefly, though, on how the initiative to reduce avoidable hospitalizations fits with the broader demo authority? It seems like that's one of the activities that should be going on under the other demo, the broader demos.

MS. BELLA: Under the financial alignment demos?

CHAIR ROWLAND: Yes.

MS. BELLA: Certainly. I mean, they're intended to be complementary, but there are certain areas of the country that are not pursuing the financial alignment demonstrations that are good candidates for the nursing home demonstration. So we don't expect there to be tremendous overlap. In areas where there is overlap, the State will have to tell us how this fits into the bigger picture so we make sure that we're not kind of counting savings twice or we're not confusing where the beneficiary would be receiving the most appropriate services.

CHAIR ROWLAND: Okay. Mark, first question.

COMMISSIONER HOYT: So you've taken some shots for passive enrollment. How would you characterize that criticism? Is it just philosophical at this point? You're just forcing people into managed care, so to speak? Will you have data that would let you keep people continuously with the same primary care provider that that've had currently? I just wondered what your view was on that.

MS. BELLA: I think that it's -- a lot of it is grounded in the context that we're moving pretty quickly and we're moving with a lot of States. And so I think then you layer in passive enrollment, which is a big change on the Medicare side, obviously not on the Medicaid side, lock in passive enrollment. None of those things -- you know, we do that to the same person in this program. So it's not -- so I guess I'm

probably the wrong person to ask. I think it's just -- it's legitimate fear of the unknown and I think the ability to make sure that we have the right networks in place and that people aren't -- the transition is going to be smooth, and I think those are all very legitimate concerns. And that kind of goes back on us on how we can monitor those things to ensure that beneficiaries are protected.

In terms of the way that the passive enrollment will be done, we have every intention of being able to use intelligent assignment or whichever phrase, something other than random, and that's why we're excited to work with the States. The States actually know how to have more sophisticated assignment algorithms. CMS just does random. And so if we relied on CMS to do it, because CMS has done it with -- they do it with the Part D low-income subsidy and it is random. We're happy that the States have more sophisticated methods that will allow for looking at things like past relationships, that will allow for looking at the differences in the formularies between the drug plans. And so we think that's a really important piece of these demonstrations.

CHAIR ROWLAND: Trish and then Robin.

COMMISSIONER RILEY: Well, Melanie, I also know that there are many people who are saying you're going too fast and too broad, and I would just like to say the National Academy for State Health Policy 25 years ago convened States to talk about this problem with the dual eligibles. This is not a new problem. This is not a new issue. I would say, it's about time. And for those who suggest that it's too fast, I appreciate the worries, and it's a big change and you've taken on an enormous piece of work. I think this resource center is very encouraging. It suggests a level of accountability and learning. To me, the breadth of this is a plus, because if you're engaged with them as the Federal Government as they move forward, it seems to me you advance the whole field and the diversity of it is a plus, not a minus.

So I just applaud you and I say, keep going, administration. It's about time. If not now, when? With your kind of leadership and experience, I just feel very confident about this and with the States.

That said, I appreciate that there are real worries and it is huge change, especially for those who are very rooted in the Medicare program and worry that it will be diminished. So I wonder if there are ways that MACPAC can help. I worry about three-way contracts. I suspect that was a compromise as you worked through these discussions. I worry about accountability in a three-way contract. Are there any kinds of issues we could take on as MACPAC that could help advance this work?

MS. BELLA: Several, I am sure. And we've had an opportunity to work with Lu and her staff on even some fundamental things, like a common analytic agenda, so we all have a better understanding of the population and the types of care models we want to test.

To the extent that you want to give us feedback on the models, we will be receiving that feedback from MedPAC. So it's probably helpful to have the perspective of Medicaid with the perspective of Medicare, and I don't know if that's something that you all do, but even informal, it's help to be able, I think, for people to see the different perspectives, and we tend to hear more from the Medicare perspective than we do from the Medicaid perspective.

CHAIR ROWLAND: Okay. Next, Robin.

COMMISSIONER SMITH: I'm not in the business. I'm the parent of a beneficiary of Medicaid, so this might just be mundane, but can you tell me, what does managed fee-for-service look like?

MS. BELLA: Sure. That's a great question, because the managed care seems to always dominated. Managed fee-for-service in these models for the States that are pursuing it is really one of two forms. One is States that are doing the Medicaid health home are building on -- so the health home is required then to coordinate the Medicare piece for the duals.

And then the second is a State like North Carolina who is taking its enhanced primary care case management, which is having care management supports, but it's still in an underlying fee-for-service environment and it's broadening whatever responsibilities of whatever entity it is on the Medicaid side to

take on the Medicare coordination piece for the duals.

And then the way the model is designed is that if Medicaid is making that investment and Medicare benefits, then Medicaid can get some of that savings back to help us at the investment, if they need quality standards and all those things.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Two questions for you. First of all, I noticed that several of the States actually are not using that passive enrollment, if I read the chart correctly, and I wondered what their thought process is, why most States are actually moving toward a passive enrollment system and why some States have opted not to. That's number one.

And number two, I'm wondering whether you've begun to think about and the States have begun to think about where in this transformation you would want to and expect to see savings and where you would actually expect to see your expenditures go up. I think that developing some framework for what we can expect based on empirical evidence in the way legitimate savings for this population and where an early warning sign of issues might be, savings that we might not want to see.

MS. BELLA: On the passive enrollment, most of the States actually are requesting passing enrollment. A subset are requesting lock in and some are not. And so I think most are requesting it.

COMMISSIONER ROSENBAUM: A couple show up, maybe that our chart is -- and I may have misread the chart, but it looked like Connecticut was not requesting passive enrollment, I think --

MS. BELLA: Connecticut is managed fee-for-service, so it could be so they wouldn't --

COMMISSIONER ROSENBAUM: So that is why. So it's those States that are using a fee-for-service arrangement that would be likely not to have --

MS. BELLA: Right.

COMMISSIONER ROSENBAUM: -- passive enrollment. And on the savings issues, I

wondered if you had --

MS. BELLA: So the savings, we do expect to see increases in the Medicaid supportive services in the beginning, and we expect those to be offset by Medicare, hospital readmission, better med management. And that's the beauty of this model, is because we're trying to provide both payers savings prospectively from day one. One payer comes earlier and the second payer comes later and that's how it works to be able to put them together. So, again, we see Medicare's short-term savings. We want to see some increases in Medicaid, we think.

Where Medicaid really, and where I think the long-term savings are, it's in the mix. It's changing the mix of institutional and home and community-based, and we're in the process of modeling within any given State. For every one percent change in mix, what does that do? You know, you can look at States who have been doing this for a long time. Arizona is a great example. The data that Arizona can show, because it's gone from, like, 40 percent community placement now, let's say, to over 65, or it could be higher. The amount of savings each year by changing that mix -- but that, you know, at a certain point, you max out on that opportunity. And at the same time that you're changing the mix, the folks that are left in the nursing home are higher cost because you have your higher acuity folks left. So that offsets some of that.

But I think, Sara, that's where we hope to see it. We want to be -- you know, we're going to be monitoring -- there are certain things -- we want to be very cognizant of monitoring the ratio of spend on the medical and non-medical to make sure that there's nothing going on there, and I'd say early warning things are going to be particularly if we some major decreases in the supportive services side. You know, you would expect to see the decreases. I don't think we'd worry a lot about decreases in readmissions and other things, but we'll be keeping an eye on, I think, what's going on with the supportive services utilization, in particular.

COMMISSIONER ROSENBAUM: So particularly with the passive enrollment system, you'd be looking for any near-term decrease in contacts between patients and their --

MS. BELLA: Providers.

COMMISSIONER ROSENBAUM: -- providers as a sign that they are somehow not understanding or not understanding how to use the system they've now been assigned to.

MS. BELLA: There's a lot that we will be doing. We have an external evaluator. That evaluator is RTI. And the States will have evaluations. But there's a lot we'll be -- I mean, this is a demonstration and we really are testing the passive enrollment. We'll be looking at opt out rates. We'll be looking at the contact rates. We'll be trying to understand -- I mean, we have a lot to learn about that piece alone, utilization and non-utilization wise.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: Okay, I will try and be brief.

Thank you, Melanie. This is interesting to get this update.

As Trish said, this has been a problem for so long. I agree with her sentiment that you need to be kind of bold and push forward with this.

However, is there any partisan pushback? I can't imagine there would be because, I mean, at least the concept is clear. I know you're going to speak at the American Enterprise Institute in a few weeks, and they have obvious interest in this.

But we have to be sensitive to the Hill, and I'm wondering if other than the providers through MedPAC have expressed their concerns about the scope of this demonstration and the passive enrollment. Is there any other reluctance on the part of people on the Hill or in Congress to do this?

MS. BELLA: I have formally testified at two hearings and have had very nice bipartisan support. If anything, at that point it was: Tell us what we can do for you. Tell us what we can do for you.

And I kept saying, well, we have these demonstrations. We need to get them up and running.

We've done briefings with Hill staff over the past couple of months because this activity has been picking up so quickly. They have a lot of questions, but I'm not -- there's no opposition to doing this.

Each party seems to have a little bit different interest in terms of whether it's beneficiary protections or whether it's more on the financial side, but by and large, we continue to get bipartisan support with the caveat that, I mean, you can never provide enough information, you know, when something is moving so quickly. And I'd say, if anything, that's what we suffer from -- is trying to keep them updated and quickly enough.

VICE CHAIR SUNDWALL: Thank you.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: Thank you for coming, Melanie, and thank you for doing this. I haven't been in the duals issue as long as Trish, but congratulations on pushing forward.

I have two comments rather than questions. One is the construct of building on medical homes. I think the concept of medical homes is important, but it actually needs to be a medical neighborhood when you're talking about this population because they have needs that go well beyond primary care, some of which are specialty care, but some of which are areas that there are basically gaps like mental health and behavioral health and dental, since we don't have our dental person here today. And those are very important in many ways for keeping these patients healthy and maximizing their quality of life.

So I would just say we should be careful about those demos that are only built on a medical home.

My second comment comes both from being a daughter of a parent with Alzheimer's who's in a facility and a CEO who runs the hospital that is the recipient of many patients, and that is one of the big reasons I see for readmission for nursing home is the failure of clarity on the part of everyone about what is it that the patient and the family really want to have happen.

And I've pushed for a very long time with no success that when people enter a nursing home they should be asked to clarify what it is they actually want and what it is that their family wants because one of the savings you may well see in this is in ambulance because we run the 911 system.

And they are always called to the nursing homes for a variety of things. The list is very long. And then they don't know whether they're supposed to transport the patient or not.

Then when they end up in the hospital, we often have no idea what the desire of that patient is for their care, or their family. And when we as providers have no information, we do everything which may have actually no positive outcome and may not be what the patient wants.

So I actually think that I don't know how this can be built into this. And this isn't really a question, but I think that that's a very much underestimated reason for readmission. And I just think that we miss that, generally speaking, in thinking through that piece.

CHAIR ROWLAND: Okay, Andy.

COMMISSIONER COHEN: Thanks.

I, first, want to associate myself with Trisha's wise comments as well. I think there's maybe more comfort with passive enrollment in managed care around this table -- at least there is in me -- because Medicaid has had substantial experience with similar kinds of things, not all good by any stretch.

But you know, we know something about it. And I think we, or at least I, sort of share your view that the status quo is not something that should be preserved for preservation's sake. So I applaud your efforts to move quickly but obviously with a lot of attention to the needs of this population.

I wanted to ask about two things. The first kind of carries on the point that Patty was making about the medical neighborhood or sort of the limitations of sort of focusing on a primary care provider as sort of like the key thing that has to be, the key relationship that people should be thinking about trying to preserve when it's good, in a mass move potentially of people into a new payment structure.

It seems like we all know that the duals population is really made up of millions of individuals, but you can also sort of group them into subgroups that are extremely distinct. There are people with really significant long-term care needs. There are people with really significant behavioral health care needs. And there are people who are Medicaid beneficiaries who are low income and who primarily have physical health care needs.

And I think to focus only on the connection with primary care and analyzing, doing any kind of intelligent assignment, and not looking at -- you know, for each individual there may be a different characteristic that's really driving their health care experience and needs.

So I don't know what your sort of communication is with states about the nature of intelligent assignment or sort of what they should be factoring in. Intelligent assignment is good, but I'm thinking it really needs to be quite sort of nuanced, to take into account the different primary characteristics and relationships that really drive the quality of a person's interaction with the health care system.

That's a comment --

MS. BELLA: Thank you.

COMMISSIONER COHEN: -- but also just curious about whether or not there is sort of attention to that in the conversation with states who have some ability to do --and hopefully, they all do -- some kind of intelligent assignment.

MS. BELLA: And there's a certainly a recognition that the populations are different. For example, folks with SMI are not -- you know, their medical home is not going to be the same as the folks that have the physical needs. So there's a recognition of that.

Each state has different levels of sophistication to be able to address it. And within -- you're talking about the managed fee-for-service model. I mean some of them are built on --

COMMISSIONER COHEN: Well, not necessarily.

MS. BELLA: Okay.

COMMISSIONER COHEN: I come from -- in New York there are sort of specialty kind of plans too --

MS. BELLA: Right, right.

COMMISSIONER COHEN: -- but a variety of models.

You can imagine someone who's in a behavioral health carve-out and they have a relationship with a behavioral health care provider. That's actually the most essential thing to preserve, not their on-paper relationship with a primary care physician.

MS. BELLA: Yes, and I think it's an important part of the intelligent assignment.

I'm not sure how nuanced it is there. It's going to be more nuanced in the requirements they have around their assessments and their care teams and their care plans because they will -- it will not be a one-size-fits-all care team. It will have to take into account what's driving a person's needs and how that team should be comprised then to meet those needs. So I'd say they'll probably get at it more on that angle, but there's certainly a recognition.

And there's a recognition on our part. I mean, we're pushing them to talk to us about different care models for different populations where different people are playing the lead role for that beneficiary.

COMMISSIONER COHEN: Thanks.

And then, the one other thing that I wanted to raise is that with respect to beneficiary -- different kinds of protections around a passive enrollment model. I don't know how much, and forgive me if I have just not seen what's in your -- in the office issuances.

But it seems like there's a certain amount of asking the states what are you going to do and then doing a sort of like review of that and sort of a little bit of like I'm not exactly sure what I'm looking for, but

I know it when I see it kind of analysis.

And I'm just wondering if there aren't -- or actually suggesting that there might some more sort of proactive standards around that, that the office might consider or that MACPAC might consider helping to recommend or develop. It might bring people some more comfort that in every state or every situation in which there might be passive enrollment, certain minimum standards will be met with respect to beneficiary protections.

MS. BELLA: So we have preferred standards, if you will, that are part of one of the guidance documents. It's around many areas, not just enrollment. Grievances and appeals is a big one. Marketing, all of those things -- where essentially, in my mind, they function -- we're saying this is the -- we look at the Federal Medicare rules, the Federal Medicaid rules. We'll look at each state's specific rules. And then we say what is our preferred standard.

And to me, it's a floor. So it is anything where a state wants to have a variance from that. The threshold test is: Is it better for the beneficiary? And so, that's how we're addressing that.

Then, specific beneficiary protections, we do have language about continuity and transition and the role in governance structures, and the use of enrollment brokers and choice counselors and notices and those sorts of things.

So it's probably not pulled out on one piece of paper that says specific. It's part of a larger document with standards, if you will, in many different areas. But your point is well taken.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: Well, we all know that states are the real laboratories of innovation. So first, I want to share with you that many years ago, when we had just this little TANF managed care program in Missouri, we had an opt-out provision, and it was because of the weird fluke where you were picking up people with disabilities who had enrolled in TANF and so they were coming into

a TANF program.

And what I want to pass on from that was that we found the people who understood opt-out the best and really were able to advocate for members who didn't belong in that system were providers, and we really encouraged providers to understand that that was an option for those families. They, of course, had an incentive to maybe not be going through managed care hoops or all those different rules, but I just wanted to share that with you.

I think after a while we phased the opt-out out because we kind of worked the kinks out, but it really worked.

So just as you're looking at ways to address concerns about opt-out I would really encourage you to recognize how important providers are going to be in making that work.

And then, my other just kind of two questions. We have -- one of the pieces that we did for our March report focused on the Medicaid-only population with disabilities, and their very high incidents of behavioral health disorders. Of course, we know that's also very common in the dual eligible population.

And I'm curious. Do you see in any of the proposals a real specific emphasis on addressing that population because they are so unique, and if so, what could you share with us about that?

And then, my very last question -- that's the first question actually. The very first was a comment, so then I have a question and then another question.

Do all the dual proposals that you've got; Melanie, are they all including nursing home care in the proposal as well as their community support services?

Thanks.

MS. BELLA: So I'll take the last one first. Yes, they are all including nursing home care. There may be a couple that have a certain month period where it would flip back to the state as opposed to -- Minnesota has been doing it that way for a long time. I don't think they seek to change doing it that way.

But by and large, especially the new states that are coming in, they're using this as an opportunity through the capitation rate to promote their rebalancing and try to align incentives to increase the community placement.

On your question about behavioral health, yes, I mean, states -- so again, they have to look at -- they have to provide us data analysis about their population, and so people are segmenting to understand what percentage of duals have serious mental illness. And they -- again, they expect to see that in the care models and the ways that the networks are developed.

A couple of states that are doing managed fee-for-service -- Missouri is focusing. Its first health home is on beneficiaries with serious mental illness so that that will be the whole target population. So certainly that's especially the managed fee-for-service states. It's an important and almost a natural place to start, especially with the health home base.

CHAIR ROWLAND: But is there -- I think Donna's question was also is there a comparable activity going on for the disability population that's not the dual population.

MS. BELLA: In our proposals, no. Our proposals can only be for the duals.

CHAIR ROWLAND: They don't reference any coordination or any work that is comparable?

MS. BELLA: I think certainly -- especially the states that have done managed long-term care or those that have their age/blind/disabled population in managed care, most of them have had the ABD and not the duals in. So they're using that framework, and they're using that foundation and bringing in the duals.

And then, there are -- you know, we don't hear as much from states about the Medicaid-only folks. We hear it from the providers, about where are they going to fit.

There's nothing preventing states from using the exact same product and the care model. We wouldn't be in the same sort of financial arrangement with them, but they're going to -- we're working with

them to get all the necessary Medicaid authorities they would need to do these types of programs. And there's no reason, if they wanted to, they couldn't do it for their Medicaid-only as well. It just wouldn't be part of arrangement because of the financing structure would be so very different.

CHAIR ROWLAND: Judy. Judy and then Mark.

COMMISSIONER MOORE: Melanie, I've said to you and I'll say publically that any of us who care about public policy between Medicare and Medicaid are very happy to have you there driving this.

MS. BELLA: Thank you.

COMMISSIONER MOORE: And I'm really pleased to see the range of programs that you've set up. It's not -- we all hear so much about the projects and the states that are involved in things, but you've got so many other supportive activities and centers and so forth.

And I really wanted to talk to you about data, both with regard to the state profiles that you've done and are doing and also the data that you're sharing with states, and to talk about the extent to which there is Medicaid encounter data in that mix that's being shared maybe with Medicare or the extent to which Medicare encounter data is helpful to states and gives them another reason to do a better job.

And I know that others in CMS are working hard on the whole question of better encounter data and more reporting of encounter data by all the states. But I think it's just a really critical problem for Medicaid, and certainly I wanted you to comment on that in the context of what you're doing.

MS. BELLA: Well, as far as Medicare encounter data being available, we're starting to collect it this year. And so, as we work with states to give them access to data, that will be a source of data that's been previously unavailable.

We don't have it yet. So when we need to get Medicare encounter data, the states either need to get it directly from the plans or CMS needs to be able to use -- unfortunately, the bid data is proprietary data. So even though we have it, we can't use it for certain purposes.

So on the Medicaid side, we, as part of this process, we get more timely data if we get it directly from the states and we don't use what CMS has. And so, as part of the rate-setting process, we will use state data that we'll have to validate. But we will have an actuary, and we will have our Office of the Actuary and then the states' actuary. So we'll all be working with whatever is the most recent and complete data that we can validate.

And so, we will be using state encounter data. We have to if we're going to be able to set rates, particularly for states that have been doing managed care for quite a while.

CHAIR ROWLAND: Okay, Mark.

COMMISSIONER HOYT: Perfect segue for what I was going to ask. I was hoping you would comment a little more on the rate-setting, how you think it's going.

I did review the chart, and most of the contracts seem to be pretty large in scope, comprehensive. Are you hoping, expecting to write a fixed rate, capitated contract from the get-go, or do you think there will be some shared risk in the early years?

MS. BELLA: States are requesting risk corridors, if that's what you're asking. We didn't design it. We were silent on whether we would have -- what sort of risk-sharing there would be.

There's certainly a recognition that with a new program for such a complex population with so much unknown that that's a good place for risk corridors. It's something that we're discussing internally as far as how it fits in the model.

As far as how the modeling -- or, how the rate-setting is working, we do initial modeling with the states, using their data, to try to understand what the utilization change opportunities and the savings opportunities are.

We don't have a national target. We can't because every state is different and comes to us with a different Medicaid managed care penetration and a different Medicare managed care penetration, a different

mix of institutional and community, and so we don't have kind of a national standardized approach with a national savings target.

COMMISSIONER HOYT: [Off microphone.] Can I ask a follow-on?

CHAIR ROWLAND: Okay.

COMMISSIONER HOYT: Have you talked to the plans at all, and would I be correct in assuming there would be one capitated rate to a plan for all the services?

MS. BELLA: The whole point of the capitated model is to have one blended rate. The feds will pay the play. Note, the feds are not giving Medicare money to the states. And the state will pay the plan, but it's one rate with three components -- D, Medicare A and B, and Medicaid.

COMMISSIONER HOYT: Have you talked to any of the plans? Have any of them asked for shared risk, or is the states at this point?

MS. BELLA: I'm sure some of the plans have commented on the state proposals, that they would like that. We have not been -- we have been contacted by the plans on other things, not so much risk corridors.

CHAIR ROWLAND: Okay, we have Denise and then Richard and then Robin and then Sara.

COMMISSIONER HENNING: Well, it's been a while. So this brought up something else, and that is the encounter data.

I work for a federally-qualified health center, and we get paid the same rate, no matter how complicated my patient is. So if I see her for a UTI or I see a complicated pregnant person that needs 3,000 things, I'm still getting paid for the same, the same rate. But when I submit an encounter, I still have to assign a level of care to that and assign diagnosis codes to that.

So I don't understand why if it's a managed care situation, why that encounter data isn't available because it seems to me you have to submit something in order to get paid. It just doesn't make sense to

me.

MS. BELLA: Why it's not available for Medicare? We've just never required it.

COMMISSIONER HENNING: How do they get paid for their visit?

MS. BELLA: They were getting a capitated rate, but they didn't have to submit encounter data the way Medicaid has traditionally submitted encounter data.

COMMISSIONER HENNING: Okay, and then my other comment. When reading and reviewing the material that you gave us, I was really excited to see the idea of care teams that could go -- like rotating care teams that could go around maybe to different nursing teams and rather than take that patient -- I'm thinking of my mother-in-law who broke her hip.

And she was in a nursing home, and there was a concern in that -- she was just there for the rehab, not to stay. But there was a concern that she might have a DVT. So they took my mother-in-law, who's 80-some, and moved her from her bed in the nursing home to the hospital in order to run a Doppler study on her.

You know, this is an 80-year-old woman with a broken hip. Whereas, doesn't it make more sense to move the Doppler machine to her?

And I'm just thinking that could work in so many different ways. You know, your UTI example. Somebody that has maybe early onset pneumonia, you could just give them a couple of doses of antibiotics. But typically, nursing homes don't really have the high-level nursing staff to be able to do that, to start IVs and to give antibiotics and definitely not to write the orders.

But you could have these rotating care teams. I mean, to me, that's an exciting concept, and I really congratulate you.

And also, I guess my second question to that is: is that being done on a large-scale basis anywhere because I just think it's wonderful?

MS. BELLA: The Evercare model, it was done in a -- it's a capitated model, but it certainly provides clinical resources onsite to nursing facilities and certainly gave us a lot of ideas on how to structure this.

Our initiative is in a fee-for-service payment environment. It's not in a capitated payment environment. But this certainly has been done and shown to be successful in other places and with some of the institutional SNPs in the Medicare managed program as well.

CHAIR ROWLAND: Okay, Richard, Robin and Sara.

COMMISSIONER CHAMBERS: I'll try not to repeat anything. There have been a number of great questions.

I think I was at the conference 25 years ago when it was discussed, but being someone who has run a health plan for the last 10 years, that has served dual eligibles, I just want to compliment you and the Administration for moving this forward because it's something that I personally have seen not only in my federal service for so many years, and some of us who were sort of the canaries in the coal mine for years, saying, the duals just need to be addressed and certainly could make progress. So, compliments and really excited about the opportunities this demonstration is going to produce.

I just have a simple question. It was actually in your vision for the financial alignment as you talked about establishing accountability for outcomes across Medicaid and Medicare. I'm just curious how you see that actually happened because that would be an amazing outcome of this, to be able to get outcome information. So I'm just curious how you --

MS. BELLA: Well, I mean, we'll be looking I think at three main areas -- quality, cost and beneficiary experience.

And so, we will have -- we have core measures. In the capitated model, we have quality withholds. In the managed fee-for-service model, there's a quality threshold that must be met before the savings target.

So I don't know if you're asking specifically what sort -- are we going to be using outcome measures versus process measures, but certainly that's the intent.

As you know, you can't get to outcome measures on day one. So we'll have a progression to getting there, but for the first time we'll be able to take -- you know, we'll be able to have a mix of measures.

So we're looking both at the long-term support and services, the behavioral health and the acute instead of kind of looking at all of it in silos, and one entity will be responsible for moving the needle on all of those things.

CHAIR ROWLAND: Robin.

COMMISSIONER SMITH: I guess I need to represent the beneficiaries again. And I do appreciate that you do seem to have a very thoughtful consideration of beneficiaries in all of the -- everything you've talked about today.

My biggest concern is that I would prefer good managed care over fee-for-service any day, for my son or for anybody. I think my biggest concern is that this is such a vulnerable population. So much of their life, their day-to-day existence, depends on their care. It is -- everything kind of spins off from that. Despite how capable they are, their care is going to dictate the type of life they have.

It's not like taking your child to a doctor to be tested for strep throat or an ear infection. It's just such a critical area. Everything revolves around the medical care they get, and so the team dealing with them just has to be really good.

And I'm so worried about the people who don't have the capacity to know that there's a grievance process or to know how to do a grievance process or doesn't have someone to stand up for them.

I do think we do need managed care. I'm not opposed to that. I just want it to be really good, and I don't know how we're going to do that.

MS. BELLA: I appreciate that comment. I mean, I think we're very cognizant of the need to do

this right and the need to transition it appropriately and to make sure that the right supports are in place.

I think we don't necessarily think that those support -- I mean, we don't think they exist in fee-for-service today. So we're just trying to figure out -- surely, we can make it better than what's happening in terms for people that don't have any idea where to turn.

And I think it really gets down to putting those supports in place -- the ombudsmen, the choice counselors, the peer supports, having the beneficiaries as part of the governance board or having them part of the -- somehow having some peer support pieces built in as well. We expect to see those things in the proposals.

COMMISSIONER SMITH: I just want to say thank you. I appreciate your thoughtfulness. I do.

CHAIR ROWLAND: Sara, did you have a closing comment?

COMMISSIONER ROSENBAUM: Actually, I think Robin and I had mental telepathy because my question was going to the point you raised earlier, Melanie, about the alignment of the Medicare and Medicaid grievance and appeals systems.

There are a lot of, as you know better than anybody, a lot of detailed differences between the two systems, but the most fundamental distinction is the amount of time that a beneficiary has between a proposed action -- whether it's by the state or the state's contractor -- the proposed action and when the action takes effect.

So if you're going to reduce or end a treatment or modify a treatment in Medicaid because of what, for shorthand, is known as the Goldberg rule, there's a period of time before the action takes effect that the beneficiary can appeal. There are limited where that's true in Medicare but not always the case.

And I wondered what your thinking, at least at this point, is about how you reconcile the two.

I mean, one is what's known literally as a brutal need model. That is Medicaid. And Medicare is

known as a program that has much due process attached to it but is not a brutal need program.

It's one of the few places I can think of where I would assume the sentiment on the part of beneficiaries is that they want to be thought of as Medicaid beneficiaries, not Medicare beneficiaries. But I wonder where CMS is in its thinking about this.

MS. BELLA: If you have time, the one thing you might do is in that guidance document there are several parts of due process and grievances and appeals where we have put out our preferred standard.

I'd say that if we didn't have to worry about cost we would make -- we'd put "paid pending" across the board. And we are trying to do that in limited circumstances where it doesn't exist in Medicare today.

But it's -- right now, that issue aside, I mean we really -- this is the core place where the principle of what's better for the beneficiary and that's what we judge by. Where states have different time frames or different processes, now that's the standard that we're going to be using. And in most cases, it flips to Medicaid, as you know.

CHAIR ROWLAND: Okay. Well, we have used this time very productively. We thank you for your comments.

And since you're on such a fast time track, we will bring you back sooner rather than waiting as long as we did this time. But we appreciate the work you're doing and your answers to our questions here. We're looking forward to your data and to continuing to work with you. So, thank you for coming.

And also, for the Commission, we will now take a break until 1:30, and we'll reconvene at 1:30 after people get a little bit of lunch.

Thank you.

[Whereupon, at 12:36 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:31 pm]

CHAIR ROWLAND: Thank you and let us reconvene.

We are pleased to move on in this next session this afternoon to two of the chapters in the MACStats that we are planning for our report due to Congress in June, and we are setting out at this first session to look at access to care for low-income adults and the comparison between Medicaid access and utilization with those with private insurance and the uninsured.

As you recall, we undertook this kind of an analysis for children as part of our March report, and now for our June report we're going to go up the age spectrum, up to but not including the Medicare aged population. So this is the adults pre-Medicare and post-child.

We're pleased to have Peter Cunningham joining Chris Peterson for this discussion. Peter, as we all know, is a well-known expert on looking at access to care issues and on the many research questions that come up around those issues.

I think, Chris, you're going to start by giving us an overview of what's in the chapter. The chapter draft itself is in your notebooks. And then, Peter, we will welcome your comments as well.

CHAPTER REVIEW: ACCESS TO CARE FOR NON-ELDERLY ADULTS

MR. PETERSON: Thank you, Diane.

CHAIR ROWLAND: It's Tab 3 in your books.

MR. PETERSON: Yes, you have the chapter, the draft chapter, as well as the contractor report that was provided by Sharon Long of the Urban Institute.

The presentation I'm going to give today should look familiar to you because it follows the outline of the chapter and it follows the outline of the chapter in March, which was on children. So I'll begin with a context for the chapter. We'll hit an overview of the methodology. I'll talk about the findings, which were structured to follow our access framework, and then we can chat about next steps. And then Peter

will follow me with some general thoughts and open it up to your questions and your feedback, which we really look forward to.

So the context for this chapter, as you know, MACPAC is statutorily required to monitor access for enrollees in Medicaid and CHIP. Our March 2011 report introduced MACPAC's access framework, and as Diane mentioned already, we had in our March report a chapter presenting findings on children's access to care. So the proposed chapter for June then is analogous for adults, and it mirrors the approach that we use for children in the March 2012 report.

As with the children's analyses, the sources of data are the National Health Interview Survey and the Medical Expenditure Panel Survey. These are nationally representative surveys of the U.S. civilian non-institutionalized population. And the methodological approach is, as Diane mentioned, to compare adults 19 to 64 who are enrolled in Medicaid to similarly situated adults who are uninsured or who have ESI. And by similarly situated, we mean that the standard research approach was used to employ regressions to control for the differing health, demographic, and socioeconomic characteristics.

In addition, there is a chapter annex that provides more detail on the data and methods and a contractor report, just as we did for March, which the contractor report was available online and is available online on macpac.gov.

So the chapter findings for adults are somewhat reminiscent of those for children in March. For almost every measure, adults enrolled in Medicaid have better access to care than uninsured adults. The results comparing adults on Medicaid to similarly situated adults with ESI is more mixed. For most of the measures, access and use are comparable, but results do differ significantly on other measures. We'll talk a little bit more about those, but the two examples here are that Medicaid enrolled adults are less likely to delay care because of costs but are more likely to delay care because the wait is too long to see the doctor at the site.

So this figure gives you just a couple measures of how enrollees in Medicaid differ from those who are in ESI or are uninsured, and these are the kinds of factors that are being controlled for. So we see that adults enrolled in Medicaid are significantly more likely to have a work limitation and are more likely to be the parent of a dependent child.

Then as we begin to look at the access measures, once we're controlling for all of these various characteristics -- and you have in your materials the appendix tables that include all of the different controls that were used in this analysis. But as we look now at the access to medical care, there was no significant difference between Medicaid and similarly situated individuals, adults on ESI with respect to whether they delayed care. But the reasons for delayed care did differ significantly. As I mentioned already, the wait to see their doctor was higher for Medicaid enrolled adults; out-of-pocket cost was less likely for the Medicaid enrolled adults; and transportation was higher for the Medicaid enrolled adults.

And then you see the top line number comparing Medicaid adults to the uninsured is that the uninsured are significantly more likely to have delayed care, and the driver of that, not surprisingly, is because of out-of-pocket costs.

Another couple examples where we look at the utilization of medical care. In this case, we're looking at ambulatory care. So whether an adult had any office or outpatient visit, not significantly different between Medicaid and ESI, but a big difference for the uninsured. And then a new measure that we put in here is whether there was any visit with a nurse practitioner, physician assistant, or midwife, and there was no significant difference across sources of coverage on that one.

With respect to specialty care and emergency departments in particular, the results show that individuals reported that they had specialist visits -- they were as likely during the year to have had a specialist visit whether they were in Medicaid or ESI, which was significantly higher compared to the uninsured. And this was a point that we explored in the March chapter, and we take the same approach in

this proposed June chapter to tease out -- this was one of the cases where we dig in a little more and explain what the unadjusted results mean versus the adjusted results. So let me just walk you through those. It's in the draft chapter, but I'll just reiterate it.

If you were to look at the unadjusted results, just the raw numbers -- and this is in the appendix tables -- it shows that adults who are enrolled in Medicaid are more likely to have had a specialist visit during the year compared to those on ESI, which stands to reason if individuals in Medicaid are sicker and need that care in a greater degree. And indeed, then, when we do the first set of controls which adjust for the health status and disability status of individuals, then we find that, in fact, individuals in ESI would be more likely to have had a specialist visit. So, in other words, if individuals on ESI, if adults on ESI, employer-sponsored insurance, were as sick and had as many conditions as people on Medicaid, then they would actually have more specialty -- they would be more likely to have had a specialty visit.

When we do the final set of regressions to adjust for the impact of demographic and socioeconomic characteristics, then those differences go away.

COMMISSIONER ROSENBAUM: Chris, can I ask you a question? [off microphone]

MR. PETERSON: I'm sorry?

COMMISSIONER ROSENBAUM: [off microphone].

MR. PETERSON: Sure, absolutely.

COMMISSIONER ROSENBAUM: Of course, any specialist visit is so jarring because certainly there's a lot of evidence to suggest that Medicaid beneficiaries have real problems with specialists. Now, I notice that you excluded an ophthalmologist, because I'm sitting here thinking, okay, well, if you ask somebody, did you go to the eye doctor, and that's a specialist, then the numbers would look good, but that's out. And psychiatrist is out. But does anybody know whether there's an underlying pattern in the specialty access problems? In other words, if what you need is management for an ongoing chronic

condition where you need to periodically see a specialist, that's a different use of a specialist from a one-shot deal where, you know, you broke your hip and as part of the setting of the hip, they need to consult with an orthopedic surgeon once or something, who comes in, comes out, goes away, you don't have an ongoing relationship.

I assume HIS doesn't let you do this, right?

MR. PETERSON: Right. It doesn't let you capture that kind of nuance, and that's actually the second point that we made in the chapter, and that is, this is one single measure of specialty care, whether you had a visit. And it is not by itself enough to say there's no problem with specialty care.

CHAIR ROWLAND: Chris, since many of the adults on Medicaid will be women who are pregnant, is the use of an OB/GYN considered a specialty visit?

MR. PETERSON: I believe it would because -- yes, I think what it says is -- I'll have to look at the specific wording.

CHAIR ROWLAND: Because I think given the distribution of the Medicaid population that's currently covered and the prevalence of women in child-bearing years, that if a visit to an OB/GYN is considered a specialty visit, it could be influencing that number.

MR. PETERSON: I will also say that one of the health-related controls we are using is whether a person was pregnant.

Did you have anything you wanted to add on that?

DR. CUNNINGHAM: I believe that it does include OB/GYN, when I was reviewing the report, yeah.

COMMISSIONER ROSENBAUM: As a specialty [off microphone].

DR. CUNNINGHAM: As a specialty.

COMMISSIONER RILEY: Can I follow up? Because I wondered, is there any -- a couple times

you made reference to this, but I think it needs to be stronger. The benefit of an ESI and the benefit of Medicaid for adults was pretty different, particularly with small group. If you look at a small group, a typical small group plan, it provides almost nothing compared to Medicaid, and how much would that influence some of these findings, because, in fact, it is covered for Medicaid, and it wouldn't be in many ESI plans.

MR. PETERSON: And I think --

CHAIR ROWLAND: I'll get to you, Denise.

MR. PETERSON: No, I'm sorry. In your packet you will see there's a figure that looks at mental health, and I think -- whether one sought mental health professional. And if I remember right, in there Medicaid was more likely to have had a mental health professional visit. And I think what that might reflect is exactly your point, that in ESI, those benefits may not be covered in a comparable way to Medicaid, and so that may be related to that. So that's why the intent of this analysis is to say the reason that we see these differences is driving in part by the benefit package difference.

COMMISSIONER RILEY: And I think we need to do a better job because it could also be psychiatry here as a specialist, and the ESI wouldn't cover.

COMMISSIONER HENNING: And I think that we also need to look at the fact that when a woman is pregnant, she oftentimes has both employer-sponsored insurance and Medicaid. So Medicaid is your secondary payer, and it keeps her from having to pay co-pays and that kind of thing.

And then the other issue is that I have seen patients who have employer-sponsored insurance that, once they get pregnant, they drop that insurance because they don't want to pay for it, and if they're just on straight Medicaid they don't have co-pays. So from their perspective, they think that they're doing better to drop their insurance and just go with the Medicaid because they're relatively healthy people, they just happen to be pregnant. And why should they pay for insurance coverage when, you know, everything is

going to be taken care of by Medicaid? That's the way they look at it.

CHAIR ROWLAND: Well, and if they have commercial insurance, they may not have maternity care covered by their insurance plan.

COMMISSIONER GABOW: Diane, I think your point is really critical. If OB/GYN isn't specialty, I think that makes this data very uninterpretable, and I think you're going to have to drop OB/GYN out of it in order to have any idea what this really means.

COMMISSIONER ROSENBAUM: What does it [off microphone] before in response to -- I forget whose question it was. You said you did an adjustment for pregnancy. How does that cure the problem of having OB show up on the specialty side of the ledger.

MR. PETERSON: And Peter will probably do a better job of explaining that than I could, so --

DR. CUNNINGHAM: I'm sorry, Sara. Could you just repeat that? I was looking for -- I was trying to look up the specialty.

COMMISSIONER ROSENBAUM: So sorry, Peter. Before, in response to somebody's question -- you know, my mind is seeping out of my head so I couldn't remember five minutes ago who asked the question -- when this dialogue first started, the response was, "But we adjusted for pregnancy." So what I'm trying to figure out is how that would compensate for Diane's observation that the OB people are in the specialty side. Does it matter -- I mean, does one sort of cancel the other? Or are they two entirely different observations?

DR. CUNNINGHAM: I think controlling for pregnancy is -- I think it just basically means it's an additional health status control. I mean, it's an indicator of the need for care. So I'm not sure that that --

COMMISSIONER ROSENBAUM: [off microphone].

DR. CUNNINGHAM: Yeah, right. So I don't think in and of itself that necessarily cancels out or offsets whatever bias or whatever might be in the measure.

I think in terms of being able to disentangle it, I believe that the way it's -- I don't think the HIS asks separate questions for each specialty. I think it asks a single question where all the specialists are lumped together. And I do want to verify or maybe Chris is verifying whether OB/GYNs are specifically mentioned.

I mean, it's a bit -- and I do have some additional comments about that, which I could hold off on, but, you know, that makes it a somewhat much -- a little bit more nebulous measure than some of the other access measures that they're using.

CHAIR ROWLAND: Okay.

COMMISSIONER GABOW: I was going to say even if pregnancy is included there in a variable way that's robust, because it's young women they still have many other visits to a GYN doctor that, even if they weren't pregnant, would alter this data, I believe.

COMMISSIONER HOYT: It just strikes me that maternity is so fundamental to Medicaid, it might be helpful to just have it broken out separately as a separate analysis. I guess my suspicion is that Medicaid would stack up pretty well against ESI in the maternity area, just off the top of my head, and it would tend to show Medicaid favorably. And if you pulled it away from all the other care, then it might show -- Medicaid might come through in a worse light the way some of us maybe are expecting on specialty care. And I think there would be value in looking at maternity separately because of its importance to the program.

COMMISSIONER CARTE: Well, I was just going to say that, similarly, the issue about pregnancy would also be for dental. When we look at the children's data, we said we would have to look at certain specialty issues separately, and that would be one also.

CHAIR ROWLAND: And dental for adults would clearly be one that you'd have to look at separately since it's often not covered by Medicaid.

COMMISSIONER HENNING: Okay. And then the other comment I wanted to make was in your previous slide, when you looked at the visits with the nurse practitioner, physician assistant, or midwife, and that being statistically basically insignificant, the difference between those, I would postulate that that is incorrect because I think that the people that have employer-sponsored insurance are more likely to know that the people that are seeing them are a nurse practitioner, physician assistant, or a certified nurse midwife, whereas people that go to community health centers assume if you are wearing a white coat and seeing them for a visit that you're a doctor. Even though when I introduce myself to my patients, I tell them that I am their "partera," they still call me, when they're talking to their children, they said "la doctora." So they think I'm a doctor even though I've told them I'm a midwife. So I don't think that those numbers are correct, if that makes sense. I think that the number of nurse practitioners, certified nurse midwives, physician assistants that are seeing patients are going to be seen -- the percentage is going to be higher in the Medicaid population than employer-sponsored insurance. So that to me is a big red flag that there's, you know, not a difference there, and I think that there really is.

DR. CUNNINGHAM: One thought that occurs to me -- I mean, I understand your point, and one thing that may be going on is that in a lot of cases, especially for maybe the commercially insured population, you know, if they're going to a regular private practice, they'll see both in a single visit, you know, whether they're -- whatever the differences between nurse practitioner or registered nurses or whatever. So that may be one reason that you see it or that it's maybe higher among the ESI population than what you would expect relative to Medicaid. And so maybe perhaps another way of looking at this is, you know, among people -- is to maybe do a more hierarchical among people who did not have any physician office visits or visits with a physician, how many used a nurse practitioner, physician assistant, or midwife. And, you know, I would guess that maybe then you would see a bigger difference between the Medicaid and the ESI population.

MR. PETERSON: And to go back, I did find in the survey -- this is the question on the specialty, so I think you'll be pleased. We'll just have to make a note of it. "During the past 12 months, have you seen or talked to a medical doctor who specializes in a particular disease or problem other than obstetrician/gynecologist, psychiatrist, or ophthalmologist?" So this note was probably reflected when we were doing the children's analysis, and we didn't include it in particular. So we will add that.

CHAIR ROWLAND: I did see in the general report there was some distinction made between adults on Medicaid who were SSI and those that were not SSI. But we're not including that in the chapter we present. Is there a reason for that?

MR. PETERSON: We can talk about that a little bit more. I'd have to refresh my memory on that. It seemed as if the key point -- and we mentioned it in a footnote -- was that a lot of the differences that existed between Medicaid enrollees on SSI versus not SSI fell away once you adjusted for their differing health status. But we can certainly look at that again and determine whether or not the Commission would like to include those results in the chapter. But they will definitely be in the contractor report.

CHAIR ROWLAND: I was just thinking that in the context of the work we did in March on disability that this is another way of looking at the disability population and how well it's served by Medicaid and that we might want to make a point of looking just at a few of those indicators there or making some comment on it to relate it back to our disability chapter.

Norma, did you have a question?

COMMISSIONER ROGERS: I was just going to make a comment. That is, in going back to what Denise was talking about, I guess I'm wondering what is the question that goes along with the nurse practitioner, PA, or midwife. How is it asked?

MR. PETERSON: Give me a minute and I will probably be able to find it, but I'm going to --

COMMISSIONER ROGERS: Because it is, I think, misleading, and if it's misleading, I'm not sure

for myself I would necessarily want it to be in a report that -- does it show that it's reliable?

MR. PETERSON: So the question is: "During the past 12 months, have you seen or talked to a nurse practitioner, physician assistant, or midwife?" And I think what you're looking at as you compare the results is that, yes, on the one hand, it's true that there is no significant difference across the board. But what I think it indicates to me is that, in fact, the uninsured are more likely to use a nurse practitioner, physician assistant, or midwife because all other measures tend to indicate that the uninsured have less utilization.

Any other comments before I proceed?

[No response.]

MR. PETERSON: So the final result, which is, again, similar to what we saw with children, is that even controlling for the health, socioeconomic, and demographic characteristics of the enrollees, individuals in -- adults in Medicaid are more likely to have had an emergency department visit compared to others.

Looking forward, these are not issues that we have -- oral health, for example, we did not delve into here, or geographic variation. Emergency department utilization, as noted in the draft chapter, we want to spend some more time and dig into that in future research, if that's of interest to you, and the relation between payment policy and access and others that you might want to suggest. And so the question for Commissioners is: Is there missing information or other outstanding issues besides those you've raised already? And then current topics requiring greater or lesser focus, and as we think about our longer-term research agenda, what other things should we be thinking about?

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: So I'm going to ask a question that probably shows that it's been years since I took a biostatistics course.

COMMISSIONER ROSENBAUM: Well, I've never taken one, so --

[Laughter.]

COMMISSIONER GABOW: So it was a challenge for me. My husband always says -- who's a mathematician -- always says that my problems with mathematics are not solved by owning a calculator, so there you go.

[Laughter.]

CHAIR ROWLAND: Your family gives you lots of advice, Patty.

COMMISSIONER GABOW: They do. They do. So I have one comment and then a question that relates to the methodology. The first is I always like to see "n"s on the bottom of charts and we never do that, and it would mean a lot more to me -- because this gets back to where my question is going to go -- I have never been comfortable with the analytics being similarly situated bases, because I have trouble grasping how many similarly situated employer-sponsored insurance compared to the uninsured. You know, so if the "n" is ten, then I would -- I mean, I know to give statistical significance here, but the size of the "n" in these groups would be very useful to me in thinking about what does this really tell us.

So my biostatistical question, which I apologize to those who are knowledgeable if this is stupid, but years ago when I was doing multi-variant analysis, the value that I saw out of that was that it told you what percent of the variability was due to a given variable. So that if the outcome variable was a specialty visit, that instead of doing the similarly situated, it could say, well, 25 percent of the variability that you see is due to the insurance coverage. Ten percent of the variability is due to socio-economic status.

To me, and again, maybe I just don't understand biostatistics, but to me, that data was much more useful in being able to understand the drivers of the outcome variable than this concept that we're using of similarly situated, which I really have trouble grasping.

So I have some other comments on looking forward, but this is a core issue about methodology that I'm just not comfortable about, the "n"s and the degree of variability for each dependent variable.

MR. PETERSON: I will just note that in the appendix tables, there are -- it's not in the draft chapter, but the "n"s are in the appendix tables and Medicaid adults was 1,828. For ESI, it was 11,671. For the uninsured, it was 3,565. So those were the individuals -- that's the number of people who were respondents for the analysis.

COMMISSIONER GABOW: But then when you get down to these individual tables where you've adjusted for all of these variables, the "n"s have got to be smaller than that.

CHAIR ROWLAND: Peter, do you want to explain what --

DR. CUNNINGHAM: Well, yes. I mean, in terms of the regressions that they're doing, it's -- there's a lot of different things that you can use the regression analysis for. Certainly, this idea of what factors explain, how much does socio-economic status or health or other factors explain access to care is certainly one of them.

In this particular case, what they're doing is saying, we want to compare Medicaid with the privately insured and with the uninsured, and because there are so many differences between those groups on factors related to health and socio-economic status that are also strongly related to access, the regression adjustment allows them to make those comparisons in a much more rigorous way than just simply looking at the simple means or the unadjusted.

I think maybe the discomfort that a lot of people are feeling is that, well, the Medicaid population is so much different. How can you compare them on like-minded characteristics? And I think that's certainly true. But I think what they've done is the best that can be done with, really, what the best available national data are on that. And I think in terms of, you know, the statistical significance takes into account the sample size which -- because that's going to factor into the confidence intervals around the estimates. And so anytime -- if you see a big difference, like if it's a ten percentage point difference and it's, like, well, geez, why isn't that statistically significant, it's probably because the samples are too small.

But I didn't really see that that was an issue. I think most of the differences, where there were differences, or substantive, meaningful differences, they were statistically significant. So I didn't see the sample size issue as problematic in this report.

CHAIR ROWLAND: You know, I think one of the things is that we're used to seeing tables that I would characterize as cross-tab tables where we count the number of visits that a Medicaid person had and we count the number of visits or the average number that someone who's uninsured had and then compare them and say the Medicaid visits were three per year and the insured with ESI were ten per year and so Medicaid doesn't have comparable visit rates. And we do statistical tests to see if those are the same.

But what we know is that the population, for the most part, with employer-sponsored insurance is higher income, is more likely to have different access. So what this regression set tries to do is to say, what we want to look at is what the effect of insurance is. We're not looking at the rate at which a Medicaid patient uses the ER versus the rate at which the uninsured person does. We're looking at the likelihood of a Medicaid person going to a physician or going to the ER compared to someone with other insurance. So you try to hold all these other characteristics in perfectly constant so that you can see what the impact of insurance is, and it's a very different thing than looking at what is the utilization rate of the different populations.

COMMISSIONER GABOW: No, I get that. I understand that. I'm just saying, for me, and perhaps it's just me and you should tell me, don't bring this up again, is that --

CHAIR ROWLAND: We could do the other kind of table for you --

COMMISSIONER GABOW: But I think that it would be useful to me, I mean, if you have 1,000 Medicaid patients, then, again, refresh my biostatistical memory, but you could have ten dependent variables. So you could put in insurance status, gender, socio-economic, level of illness, and then you could say, the difference in this outcome variable is 70 percent related to X versus Y. I find that, in terms

of my own understanding --

CHAIR ROWLAND: Patty, we can just do coefficients for you. We can give it to you.

[Laughter.]

COMMISSIONER ROGERS: That makes sense to me. That makes more sense to me than just to have it like this because it's hard for me to believe that when I look at utilization of medical care, ambulatory, or access to medical care, why we don't access or we do access medical care, that -- it doesn't reflect what the literature states and that's what I keep going back to, is that the way it's presented doesn't reflect what the literature states. I've just finished reading an article during lunchtime about the utilization of medical care by Hispanics, older women, under the age of 65, and this is not what was being said in there. And maybe they didn't have that many Hispanic women in their population of their survey, but this is not what the literature states.

CHAIR ROWLAND: Okay. Steve.

DR. CUNNINGHAM: Well, I think the way you have to look at the estimates of the report is that it's a very broad snapshot of the Medicaid population, of the adult population, and so it's including all groups. And so it's certainly possible that what's true for Medicaid in general may not be true for certain subgroups within Medicaid, whether it's racial and ethnic minorities, whether it's people with particular chronic diseases or other factors like that.

So I think, certainly, there's lots of possibilities for digging deeper, you know, beneath these results and saying, okay, how does this differ for Medicaid enrollees who are Hispanics or African American or have particular chronic diseases? But I think, from my knowledge of prior research based on household surveys, nationally representative household surveys, the results are generally consistent.

Now, I do agree with Sara that the finding pertaining to specialists doesn't ring quite true given what we know about problems with Medicaid enrollees as well as uninsured being able to access a specialist. I

mean, they have access to community health centers, but specialists generally aren't available at community health centers. And I think, again, that has something to do with it's a very broad measure casting a very wide net, and to really get at access to specialty care, you've got to dig deeper. You've got to look at particular conditions or particular providers. It's probably not sufficient to draw conclusions about specialty access based on one broad measure. But I would say that the more general measures pertaining to unmet need and the barriers that people are encountering in getting care, that those are probably the best kinds of measures that you get in a household survey because you're basically asking people about their own experiences. And so that's the way I would look at it.

The other issue I think we've got to make sure that we're aware of -- and the researchers were very careful about this, and in the contractor's report, they acknowledge some of the caveats and that there may be other factors, like severity of illness and just sort of general predisposition to use health care that may be factoring in here but are not available in the survey data.

But I think that we're still dealing with observations at a single point in time, and so we can't assume here -- we have to be very careful of attributing causality to those findings, and the researchers are very careful about that. They're simply saying, here are the differences between Medicaid, ESI, uninsured, accounting for these various differences.

It's a different question, which is much more difficult to answer with data like this, when you say, what happens when people get Medicaid coverage or what happens when they lose Medicaid coverage. You need more longitudinal data for that, and that's generally not available, at least on a national level. There are other studies that have been done. One that was done a few years ago that received a lot of attention was in the State of Oregon which, because the State had established some lottery system for enrolling adults in Medicaid, that sort of presented an opportunity for kind of a natural experiment and so they were able to follow these newly enrolled people over time and observe that, well, yes, enrolling in

Medicaid does increase their utilization, inpatient care, specialty care, ambulatory care.

So in that sense, I think the longitudinal results are broadly consistent with this. And I think -- but I think the researchers have been careful in terms of how they characterize the results. But that is one of the limitations of cross-sectional data that's looking at a single time point.

COMMISSIONER WALDREN: Yes. My point was that maybe we should have some type of analysis of the literature on this. I mean, we're talking about a bunch of anecdotal things of why we don't like this data or how this data may be wrong, but I'm just wondering about doing a kind of a literature review and saying, okay, well, here's the other -- because if this data would show what we thought, we probably wouldn't be picking on it, either. So if we looked at the other data, we could probably pick on it, too, and show that the answer is probably somewhere in between.

COMMISSIONER HENNING: Yes. I'm channeling my inner Burt. I think that our main problem with what's written so far is that you're trying to make everything all other things being equal and then looking at it. But we know that the Medicaid population is not the same. So we lose that nuance of the people that access Medicaid as a form of payment. So I think that that's probably our issue. If we could look at it both ways, you know, this is adjusted and this is unadjusted, then we probably would feel a little bit better about the data.

And then I think that there's also another issue that when you look at the uninsured population, I look at the uninsured population in three kind of categories. One is the uninsured that are basically undocumented immigrants that probably will never be able to access insurance until they become citizens, if ever.

And then there's another set of people that don't have insurance that are poor but not poor enough to qualify for Medicaid, but also not rich enough to be able to buy their own insurance, and they don't have access to it through their employer.

And then you have a group that probably is much better off financially that are kind of the self-employed people who, you know, because they're a one of operation -- they might be a small company or they may employ two or three people -- the insurance costs for them are so high that they really can't afford insurance. So what they do is they kind of save up their money and pay for medical care as they need it.

But when you lump those three groups together, you may lose a little bit of definition because of the different types of populations that you're looking at.

DR. CUNNINGHAM: I mean, I think that's a great point. There is variation within these groups, you know, including the uninsured. You know, in terms of the undocumented immigrants, I think the data allows you to -- I think they identify whether somebody is a citizen or naturalized citizen or non-citizen. Generally, surveys don't try to ask people whether they're undocumented or not because the answer wouldn't be credible and they may not answer it anyway. But, I mean, I think it's a good point and I think that's part of maybe digging deeper into these findings, that, you know, let's compare certain people who may be -- or certain groups of people who maybe are more comparable in terms of their situation in life.

But again, I do think just having the broad comparisons, adjusting as well as they can for the differences in characteristics, still has value, realizing that it does have limitations. And those limitations are mentioned in the contractor's report. I mean, maybe that needs to be discussed a little bit more in the regular -- in the MACPAC report.

Certainly, I mean, I agree that I think there's numerous opportunities and need to really kind of go beyond the broad snapshot and get more into specific populations, specific types of services.

CHAIR ROWLAND: I also think, per your earlier comment, that maybe sharing the results of the Oregon experiment and the research that's gone on there, where you did have a control group because of

the lottery with the commission members, would be another study that would be useful to look at. Kate Baicker, who is one of the lead authors of that, maybe could come.

Wait. Donna, you're out of order.

COMMISSIONER CHECKETT: I'm sorry?

CHAIR ROWLAND: I've got Trish, Patty, Sara, Andy --

COMMISSIONER CHECKETT: I didn't know what the order was.

[Laughter.]

CHAIR ROWLAND: There's rules, Donna.

COMMISSIONER RILEY: I actually think this conversation, again, is foundational to our work, because if we're to weigh in on what is access, the definition becomes absolutely critical. And while I agree that the variables and the coefficients are critical to give us comfort, they're also not what bring a broad public understanding and bring the Congress to conclusions. And so what I applaud is the notion here to try to make an apples-to-apples comparison and to look, because otherwise, we really haven't shown anything for that access if we're showing fundamentally different populations.

So I think there's a value here, but what we have is a discomfort about the phrase "similarly situated," and when you read it, it almost feels like, and I don't mean this -- this sounds more critical than I mean it, but it almost sounds like we're trying to make a conclusion, because there's so many machinations about how we use the data. So I think, more than anything else, it's more of a descriptive challenge of how do you talk about what is similarly situated? How do you translate the coefficient and the variables stuff to get to these charts, because I do think there's utility to an apples-to-apples comparison. We just need to find a way to describe the methodology -- easy for us to say -- in a way that's a little bit more accessible and that engenders more trust in what that methodology is.

CHAIR ROWLAND: I think the researchers used adjusted and unadjusted, which is the research

term, I think. We came up with "similarly situated" in our child report, trying to describe what "adjusted" meant, and maybe we can revisit that or at least have to have a better definition of that.

Now, I have Patty next.

COMMISSIONER GABOW: Well, I actually -- I know I said I wouldn't say this again, but I actually --

[Laughter.]

COMMISSIONER GABOW: I have no discipline.

[Laughter.]

COMMISSIONER GABOW: I disagree that -- I do think that the major determinant of the outcome can be something that Congress can grasp on. If you say the major determinant of the variability is the level of your illness, that's -- you can understand that. Or the major determinant of the number of specialty visits you have is your kind of insurance, and that determines the most of the difference that we see.

I actually -- when you say coefficient of variability, of course, you lose the world. But if you put it in the language of what it says, it actually can be more grabbing than this.

But the point I was going to make before you --

CHAIR ROWLAND: Provoked you.

COMMISSIONER GABOW: -- provoked me to say what I had to say again was that I think a general principle that sort of gets to Steve's comments and others, is that when you know you're putting something out there that people actually don't believe to be true, either they don't believe it to be true from their experience or their prejudice or whatever, you need to address that front on. It can't be just sort of there.

So when you say, we show that their specialty visits are the same, there needs to be a review both of

the literature and then an explanation. We think that the reason we show this when it's contrary to everybody's belief who works in this area -- I mean, you don't have to word it that way, but -- are these reasons. But I think to ignore that the rest of the world is going to say, that can't be true, requires both a look at what's been said before and why you think what you're saying is contrary, and I don't see either of those captured right now.

And while I have the mic --

[Laughter.]

COMMISSIONER GABOW: -- the outcomes, this sort of looking forward --

CHAIR ROWLAND: We're going to implement a five-minute rule someday.

[Laughter.]

CHAIR ROWLAND: You can go. Not yet.

COMMISSIONER GABOW: So under looking forward, I wouldn't do geographic variation. I think the Commonwealth is doing a lot of good work in that area and I don't think we need to reinvent that wheel.

I do think that the oral health, the ED utilization is important. The others that I would add is psych in or out. Does that influence outcome? I personally believe that the carve-out is a disaster, and I know you've heard that before. So I think both psychiatry sort of as a global thing and then the delivery model on its influence of the outcome is important.

And I think specialty care is yet an open drain. And I think procedures are really important, because -- you may have said this, Sara, but going to see a cardiologist once is very different than getting a stent. Going to see a ophthalmologist is very different than getting your cataract removed. And we can go down a whole list. I think cataract, hernia surgery, cancer treatment, transplant, joint replacement, these sort of actual hard interventions -- we've got to get to sort of not just process, but sort of the end game.

And the ultimate end game -- my grandfather always used to say he didn't want to go into a hospital because you only came out in a box. But mortality --

COMMISSIONER ROSENBAUM: [Off microphone.] Did he say that before the Roman --

COMMISSIONER GABOW: I have a whole list of my grandfather's sayings on the wall in my office. He was a philosopher that no one knew about but me.

But anyway --

CHAIR ROWLAND: But we're all learning.

COMMISSIONER GABOW: -- mortality is really a hard end point, and so in all of this, I think we have to look at hospital mortality by payer and lifespan and death from a preventable disease. To me, those are the ultimate outcomes and we really -- these other things are great, but if you die 20 years sooner, if you don't survive a hospitalization as greatly, as much, these are the end points that I think people really care about at the end of the day.

CHAIR ROWLAND: Well, I think we did hear this morning from Rick Kronick that diabetes was going to be one of the issues they looked at, and I think that goes to your point of getting beneath the broadest average to what's happening in specific situations.

And the next person down is Sara, then Andy, then Donna, and then Robin. Is yours on this point or a different point? Okay. Then you have to wait.

COMMISSIONER ROSENBAUM: Just to add one more dimension, I thought that Steve's idea of a literature, sort of adding the literature into this is a great idea.

The other thing is, I think it's important to make a number of observations about sort of the framework in which the care is being delivered. For example, it is still the case that the Pregnancy Discrimination Act does not affect employers of under 15. And, of course, mental health parity has limitations. So, in other words, one would expect for reasons having to do with the way employment law

is structured that certain things actually would look much better in Medicaid, and I think we should make that point. I think people should understand that it's not that Medicaid is so good because it's so good on its own. It's good because there are structural rules about Medicaid that are better. God only knows, that may trigger a whole bunch of calls for Medicaid protections to go away, but I think it's important.

The other thing is that there's an interesting interaction between the ED figures and the specialty figures which I think is worth at least a short note. It's not as powerful as it used to be, but, of course, EMTALA gives you as a legal matter some access to on call specialists. And I've always suspected that some of -- and I think, actually, you guys have noted this maybe in the Center for Studying Health System Change materials, that some of what we see in ED use is because it is the only way to get access to on call specialists. And that ends up boosting -- may end up artificially boosting the Medicaid specialty numbers to the extent that, for example, if you are looking at a health center, chances are if you've got a really sick patient, you're going to be better off sending the patient, unless you're lucky enough to be part of the Denver health network, to an emergency department just to get a rheumatologist consult, to get a consult that you can't get otherwise.

And so I think these nuances ought to come out in our writing around this so that people understand that these numbers that they're seeing, the flat numbers, are the product -- not only are there all of the qualifiers that we're talking about, but they're the product of many things. And then we ought to reflect that in what those things are and what the implications are. But to have a health care system where you basically have to send a patient to the emergency department to get a rheumatology consult is really a problem. And to the extent that it's inflating the access numbers, that's a bad thing.

COMMISSIONER COHEN: I will try and be brief. First, one more question about a patient caveat. I think I understand that everyone -- all the people here -- sorry. Let me start again. People who did not have a particular kind of coverage or lack of coverage for an entire year are not included here,

and I -- are not included in the analysis in order to make it more sort of pure. But I wonder, again, from the experience of like churning in Medicaid -- I mean, a lot of people on Medicaid, because you have to renew every year, do not have Medicaid for an entire year. And there might be unique characteristics -- maybe not unique characteristics but certain characteristics of those who do have Medicaid for an entire year that make them different from the general population, so just curious if that is in any way addressed or if that's another caveat we can put in there.

MR. PETERSON: Well, I would just say that we had that as a caveat, as a looking-forward issue for the children because it was -- but I can put that back in because it obviously is as important for adults as well.

DR. CUNNINGHAM: Yeah, and I think it's -- in terms of just for research purposes, it's, you know, justifiable what the researchers did. But I do think this group that are part-year insured or part-year uninsured is still relevant to look at because I think other studies that have been done have showed that people who are part-year -- who are uninsured part of the year or insured part of the year look more like the uninsured all year rather than having insured. And then as you say, there's the churning issue, which is really only going to get worse when national reform is implemented because then you've got the insurance exchanges coming online, you've got more people eligible for Medicaid. And so I think that's definitely an important issue to look at in the future.

COMMISSIONER COHEN: And then my other point is just to make this pitch probably in every chapter that we talk about, I think we should -- I mean, clearly there's a lot of sort of hesitation around the table about the limitations of the data and, therefore, what we can actually sort of say that's meaningful and actionable out of analyses of that data. And I just think we should, you know, as a theme, we should highlight some of those limitations and put down our -- you know, sort of like just document what could make -- what kind of, you know, better data could make a better analysis possible. I feel like

that should be a feature of much of what we -- you know, much, if not all, of what we put up. You know, just sort of start, you know, building more and more of a case and helping us to prioritize maybe when the time comes, like what really are the critical data pieces that aren't there, what's maybe not as critical.

CHAIR ROWLAND: And also to remind people that these studies are based on self-reported surveys and are not based on claims data, which I know if Burt were here he would want us to be making that point as well.

COMMISSIONER CHECKETT: Thank you. I have actually, I think, a relatively short comment. I'm actually looking at the draft report, and there's a Figure 1-3 on demographic and socioeconomic characteristics of adults, and making a point about a higher percentage of individuals on Medicaid who are reporting themselves as black, and I'm just wondering if we also have information on other races and ethnicity, and perhaps to me it would be more informative if we could show, for instance, people who are Hispanic. And I don't know however else that's broken out. And also anything on literacy. So just really a comment there to provide a richer picture of individuals on Medicaid compared to those who are employer-based insurance.

Thank you. That's it.

COMMISSIONER SMITH: I am getting on to a different subject. Going back to page 3 and the chapter findings for adults with Medicaid, I found the wording kind of odd. Maybe all of you all understood what he meant, but where it says, for instance, "Medicaid enrolled adults less likely to delay care because of costs but more likely to delay care because wait is too long." Does that mean that they were delayed or that they chose to delay care themselves?

MR. PETERSON: Yeah, the question is: "Did you delay care in the past year for any of the following reasons?" And then it's: "Did you delay care because the wait in the doctor's office is too long?"

COMMISSIONER SMITH: Oh, so it is actually that the person in a way made the decision or made the choice to delay care because they didn't want to wait? Or is it -- I mean --

MR. PETERSON: I think it could be all of the above. It's hard to tell. It's just asking -- it's just a very simple question to individuals, did you delay care because the wait is too long in the office where you go, essentially.

CHAIR ROWLAND: Isn't the question first did you delay care, and then they ask you to give the reason.

MR. PETERSON: Yeah.

CHAIR ROWLAND: And if you're uninsured, the reason was more likely to be because of cost, and if you had Medicaid, the reason was more likely to be because it was a longer wait for an appointment, or whatever. So those are the relative components for the different individuals of why they delayed care.

MR. PETERSON: And on page 8 is where the more detailed -- the whole table.

COMMISSIONER SMITH: It just sounds like strange wording to me.

DR. CUNNINGHAM: Well, the question is sort of designed to kind of get at differences between, you know, the financial barrier to care, because people can't afford it or their insurance doesn't cover it, versus a barrier related to the system capacity, because either the physician's office is full, it's busy, or perhaps they're not accepting many Medicaid patients. So that's kind of the distinction that the question is trying to make, is to get at different types of barriers that people encounter in getting care.

COMMISSIONER SMITH: The question to me would be: "Was your care delayed because of" instead of "Did you delay care," I guess. Does that make sense?

DR. CUNNINGHAM: I'm not sure exactly what the--

MR. PETERSON: It says, "Have you delayed getting care because once you get there you have to wait too long to see the doctor?"

VICE CHAIR SUNDWALL: It is asking their decision [off microphone].

CHAIR ROWLAND: Yeah.

COMMISSIONER SMITH: Okay.

VICE CHAIR SUNDWALL: It strikes me as I've heard all these misgivings or constructive criticisms of methodology. Chris started off by saying this study mirrors what we just published in March. Does that mean that what we've done for CHIP is not valid or we ought to revisit that? Or is that population that much different than the adults this is focusing on?

COMMISSIONER CARTE: I think it is just the same limitations that we discussed before, really. That's what I was trying to say earlier.

MR. PETERSON: Yeah, and I think a lot of these points we tried to, for example, walk through what the unadjusted results were so that on specialty care we've kind of gone through that. Here are the unadjusted results, here's what happens when you do all this stuff. And, also, this is -- you know, on the specialty care, this is one measure that you would need data that looks at -- to give a complete picture of specialty care, you would need claims data, et cetera. And so you've raised additional points that we could further flesh out kind of those caveats, where, yes, again, this is a single measure, not complete picture, and there are a lot of things that, you know, you suggested, I think, that are great comments.

COMMISSIONER HENNING: I think it would be useful to do some sort of survey of the providers that are working in the clinics because I know in my community health center that there are a lot of diabetics that are being taken care of by primary care physicians that if they thought they had access to an endocrinologist, they would probably send them to one. But they know that they're not available and that they're not going to get that consult. So they do the best they can with them, managing their care in the clinic, and they've probably gotten pretty good at it. But the thing is that, you know, if it were truly available to them, to the Medicaid patient, they probably would send them out. But there is a long list of --

I can't get a GI specialist. If I have a person that needs a gall bladder removed, it's not going to happen. She is going to bounce back and forth between the ER until somebody finally, you know, takes pity on her and takes the gall bladder out or she gets pancreatitis and then they have to take it out. But it's just not happening for her. So a lot of these ER visits are because they don't have access to surgeons that they need.

DR. CUNNINGHAM: I would just mention as a plug for my organization, we are actually in the process of doing a study. It's not a survey. It's more of a qualitative study. But it's interviewing health centers, and it's asking them about arrangements -- or how they deal with access to specialty care, especially focusing where they're trying to make arrangements with other providers in the community, and it's being funded by the Commonwealth Fund. So, you know, at some point, probably later this year, I think there will probably be a completed report or something, and we'll be happy to share that with the Commission.

CHAIR ROWLAND: And there's an earlier study that the Commonwealth Fund supported that shows how community health centers have limited access to specialists, so this is a nice follow-up.

COMMISSIONER CARTE: Just a general question, since we all seem to want to hone in on what would be a true apples-to-apples comparison over time and probably related to condition or diagnosis, to hone in to what we really want to see about specialty and access. Are there data or studies out there? And maybe the staff would know. Or is this all going to be in the "to be determined" category?

MR. PETERSON: I would say, kind of a follow-up on Denise's point, that this particular study is based on household surveys, and we note that there are provider surveys, and that is certainly an area we want to look at. And once of the citations that we gave with respect to specialty care, if I remember correctly, we cited that, and that was where they surveyed -- GAO had surveyed physicians and said, "Do you have a problem referring your patients to specialty care?" And they found that for Medicaid enrollees it was a much bigger problem.

So, again, it's about the perspective that's given, if you're interviewing providers, if you're interviewing households, and so trying to bring that all to help create that picture when we are only looking at one little slice is kind of the challenge with this. But I appreciate your feedback.

COMMISSIONER CARTE: Could I just say --

CHAIR ROWLAND: Go ahead.

COMMISSIONER CARTE: Anecdotally, that's what we hear in our state, that providers of Medicaid recipients will say that they often won't refer or tend not to refer because they feel like there is no one there to pick that patient up.

COMMISSIONER ROGERS: This is just a quick statement. I'm looking at your draft report also on page 5. I guess when you make statements or when it's written statements, for example, "Adults with Medicaid are more likely to be black and to be parents of dependent children compared to adults with ESI and uninsured," I would like to see a reference for that.

MR. PETERSON: That's in the technical appendix, and this kind of responds to your earlier question. So last time, we had put in Hispanic, and, you know, the comment was, well, let's see some other things. So we put black in to be something different, and you can look in the technical appendix, and it has -- those tables that we've provided have black, Hispanic, a whole bunch of other stuff.

[Inaudible comment off microphone.]

[Laughter.]

MR. PETERSON: You said that, not me.

COMMISSIONER GABOW: Just to follow up on a comment that both Sara and Andy made, Sara, are you aware that -- I actually had never heard this before, about the relationship between the ED and specialty, we experienced that. But I've never heard someone actually draw that --

COMMISSIONER ROSENBAUM: Oh, yeah.

COMMISSIONER GABOW: -- that they should be linked, because we hear this all the time, that the providers at the community health centers say to us, "Well, Patty, we tell our patients if they need a specialist, they should go to Denver Health ED, and then they'll get to see a specialist." So that's worth, if that's known, sort of calling that correlation between ED visits and specialty visits.

The other thing I would like to talk about is Andy's comment about the year, that they have to be in a category for a year. A number of years ago, when we tried to do a study to look at this Denver Health, we couldn't find hardly anybody who was a year in anything. So we ended up, when we did our study, saying whatever your most visits were in for that year was what we called you. So I would be interested in knowing if you took the whole n of your data set, how many people dropped out because they were not in a category for a year? Because I think that would be another important comment for us to make in this chapter, that, you know, the universe was -- I don't know what the universe is in these studies.

CHAIR ROWLAND: I think we need to start this chapter with a demographic table of who's in the sample and who was in the part-year part and what their key demographic characteristics are pre-control, just straight numbers of who's where.

I also think that we're hearing quite clearly from you that you want more of the literature review that might help explain some of these findings or put some context on it. And I think we did discuss with the children, and it's coming up again here, that really a much better look at the use of ERs and why people go to the ERs and how that differs for adults and children and whether that is, in fact, contributing toward the need to get specialty care. And I know that in many of the -- in a lot of the work that Peter and his team have done and others, looking at ED use is really a good window to try and get at where some of the gaps are out in the community.

COMMISSIONER GABOW: Getting my room denied last night has had this --

[Laughter.]

COMMISSIONER GABOW: I think that I would be good at the end of this chapter, since we just did the children's, to have a comment about how did they differ and how were they the same, because it's like we don't want to forget that we just did kids.

CHAIR ROWLAND: As well as maybe wherever we can link what's in this chapter back to the disability chapter that we just did as well.

Okay. Well, I think we've had Chris, and we thank you for coming, Peter, to talk about a study that you're not even the author of, and Chris for your once again trying to help us through regression analysis and similarly situated individuals and how this all works. The world of health services research has challenges, but it also has contributions, and we'll work through that as we work on this chapter. But thank you both. And since we seem so obsessed with data, we're not going to move on to data. Lois gets to come up and be the next data maverick.

Thank you both.

DR. CUNNINGHAM: Thank you.

CHAIR ROWLAND: We welcome you, Lois, to talk about data for measuring access. I don't think we've had enough discussion of what access is or how to measure it, but we are trying to work through our framework and work through how to do these various measurements. So with that, Lois, let's kick off this part of our discussion.

CHAPTER REVIEW: DATA FOR MEASURING ACCESS

MS. SIMON: Listening to the prior discussion, I kind of think I should have come first because now that I think about it, I'm here to give you kind of a complete picture of what our work has been on access, not just one of many parts. So, anyway, as I said --

[Laughter.]

MS. SIMON: I'm going to give you an overview of what we've done to date on monitoring access

to care in Medicaid and CHIP and our proposed next steps for moving forward. I look forward to receiving your comments as well as any guidance you may have as we continue with the development of our complete access monitoring approach.

With respect to access, as Chris mentioned, MACPAC was given two explicit charges: the first being to review and assess the effect of payment and other Medicaid and CHIP policies on access to covered items and services; and the second is to identify provider shortage areas and other factors that affect or have the potential to affect Medicaid and CHIP enrollees' access to care or health status.

So, as you know, over the past 20 months, the Commission has initiated a series of activities to examine how access to care is monitored for enrollees at the federal, state, and local levels. And as Chris mentioned, in researching our monitoring activities, the Commission -- we revisited our initial access framework, and we propose for our access-monitoring approach to leverage the framework as the foundation for our continued research on access for prioritizing our areas of study and for updating certain elements of the framework as our work evolves. And as a reminder, our initial framework has three key components: enrollees and their unique characteristics, provider availability, and utilization.

Access-monitoring activities ideally should assist with detecting existing, emerging access issues as well as address whether or not enrollees have appropriate and necessary access to health services. And our work looked at activities that could help identify emerging issues or concerns in both the immediate as well as to understand longer-term trends.

As you'll recall, MACPAC conducted preliminary discussions with all state Medicaid directors to determine what types of activities they undertake to monitor access to care for enrollees, and also how they would know if an access problem existed in their state. What we found is that all states have a system in place for monitoring access to care for Medicaid enrollees as well as a way for the rapid identification of immediate access issues that have a potential to imminently impact enrollees' access.

With regard to types of data that provide a more expedient identification of potential hot-spot issues, all Medicaid directors reported that providers, advocates, or others would raise a warning on behalf of an individual or community. Other sources that may trigger potential problems include monitoring enrollee and provider complaints and grievances and tracking changes in enrollee enrollment or provider participation.

California recently adopted a plan for monitoring access for their Medi-Cal program. The state identified 23 measures to be continuously tracked and reported on an annual basis. A subset of the 23 measures will be used as an early-warning mechanism to alert the program of potential problems, and these early-warning measures are ones that are available first more quickly and also can be evaluated throughout the year, and they included changes in Medicaid enrollment, provider participation rates, service rates per thousand member months, and helpline calls, which will be categorized by reason for the call and geographic location.

The process of monitoring access also includes activities that can indicate trends and variations over a longer time frame. Monitoring trends and looking at access with respect to particular subgroups of enrollees and particularly types of services provides essential information for analyzing the effectiveness of both program policies and programmatic changes.

On a continuous basis, administrative data, which we've heard about today, may serve as an important source of information on health access indicators. All states maintain administrative data on their Medicaid and CHIP enrollees, including information on eligibility status, periods of enrollment, and health care utilization. Claims data can provide insight into the types of services used and the providers serving those enrollees, and in states with Medicaid managed care, encounter data may provide useful information in developing utilization indicators. And also managed care contracts often define specific requirements when it comes to provider networks and quality review.

So, again, looking at California's monitoring plan, many of the state's measures focus on administrative program data that are readily available and can help to monitor trends in enrollment by specific subpopulations, provider availability by geographic distribution, and provider type and utilization. So I think combining the use of early-warning indicators with longer-term ongoing monitoring activities can provide more of a complete picture or mechanism for identifying access issues in both the short term and the long term.

Information about access and potential access issues may also be derived from HRSA's designations for areas having provider shortages or being medically underserved, which Sara talked about earlier on today, and these are health professional shortage areas, or HPSAs, and medically underserved areas, or MUAs. And both of these designations are used by over 30 Federal agencies to determine areas, populations, or facilities that are eligible for Federal aid, assistance, and special policy consideration.

HPSA designations are based largely on provider-to-population ratios for areas within a state, and they can either be for an entire population or a specific underserved population. There is a Medicaid HPSA that is based on the provider supply available to Medicaid enrollees. However, there are very few applications that are received for Medicaid designations, and these designations are concentrated in only nine states. And this may be due in part to the difficulty of obtaining localized Medicaid population and provider data for a specific given area.

MUA designations emphasize the health needs of vulnerable populations. They incorporate the primary care physician-to-population ratio, the percentage of population below the Federal poverty level, the percent of population aged 65 and older, and the infant mortality rate. And as of March 2012, there were only four states with designations specifically for the Medicaid population.

The Affordable Care Act required the Secretary of HHS to appoint a negotiated rulemaking committee that was charged with developing new methodologies for designating medically underserved

communities and populations. Again, as was mentioned earlier, the committee's report was submitted to the Secretary on October 31st of last year and included recommendations on updates to the current methodologies.

In voting on the recommendations, 90 percent of the voting members endorsed the final report, and individual votes were taken on recommendations for each of the designation types. The final report urges the Secretary to implement the recommendations which received full committee consensus, and at this point an interim final rule on the revisions to the designations has not yet been issued by the Secretary.

However, as Diane mentioned earlier at the May Commission meeting we plan on having Ed Salsberg from HRSA come and talk to us to summarize the committee activities, findings, and the recommendations.

Another area that we researched to determine its applicability to access monitoring was the U.S. Public Health System. While there are a variety of different methods that are used in public health surveillance by the CDC and which were actually discussed in an earlier Commission meeting, a model most relevant to access monitoring may be Sentinel Surveillance and Sentinel Events, and these systems rely on certain providers who are working in locations where they are most likely to observe potential problems in how the system is functioning. They focus on critical points among selected providers to gain insight into the system as a whole. And for monitoring access, we think emergency room and safety net providers could function as sentinel providers to assist with detecting changes in patterns of care for Medicaid and CHIP enrollees in a given community. So by analyzing data to detect changes in the number and types of visits for enrollees at a particular site could provide a mechanism for analyzing problems with obtaining care within a whole community.

CHAIR ROWLAND: In terms of the sentinel monitoring, does that also view the ED visits?

MS. SIMON: Yeah.

CHAIR ROWLAND: So that would be one source of looking at why people are coming into emergency departments, and they would have that by insurance status as well.

MS. SIMON: So if you see an increase in trying to understand the reasons why digging deeper into a small community it might indicate access problems.

COMMISSIONER GABOW: We are one of the BioSense sites, so, yeah, one of the things they use is our ED visits and what the ED visit was for -- fever, you know, because if they're looking -- yeah, or, you know, rare disease or whatever. So they do have -- that's one of the main things they monitor, is ED visits.

I don't know if we get insurance data, though on the BioSense. I'd have to look at that.

MS. SIMON: Yeah, I think it's used a lot for influenza monitoring, too.

Now we're moving on to surveys, which can also prove useful for monitoring trends in health outcomes, access, and utilization. While national surveys provide a rich source of data -- and we've just been talking about them -- it may provide a baseline understanding of access at the national level. There are some challenges and limitations in their applicability to an access-monitoring approach.

First, national surveys typically have limited questions on access, and the expense to modify existing surveys would be costly.

Other challenges include their limited ability to examine state-level variation as well as their often substantial time lag between data collection and reporting of results.

But one exciting addition to the 2011 National Ambulatory and Medical Care Survey is a question asking whether the physician is currently accepting new patients into their practice, and for those who answered yes, there's a follow-up question about the types of payment accepted, such as Medicare, Medicaid, self-pay, or private insurance. So we look forward to learning more about the survey results, which I'm thinking probably in the summer we'll know more.

The information I reviewed represents a basis for a draft chapter on data for monitoring access to care in Medicaid and CHIP. Over the next weeks, we will continue to develop a better understanding of current and future monitoring efforts underway in our Federal and state agencies as well as gaining more detail on measures that are available from federal household and provider surveys, so probably a lot of the literature review that we were talking about earlier, and trying to understand whether they could be leveraged in an access-monitoring system.

We heard this morning from Rick Kronick about ASPE's efforts, and we will continue to explore other initiatives out there.

So I look forward to your feedback.

COMMISSIONER ROSENBAUM: So I want put a radical proposal on the table here.

CHAIR ROWLAND: See, Patty, that's why I let Sara go first.

[Laughter.]

COMMISSIONER ROSENBAUM: We've talked -- and we've talked about this before -- about the need to make information useful to policymakers, particularly Congress, available in a timely fashion. And if we -- putting aside the strengths and limitations of the various data sources, I'm wondering whether given the increasing focus on Medicaid right now -- I don't know how it could increase any more -- the intensity of the focus on Medicaid right now, we don't want to think about a Commissioners' letter to Congress that rapidly pulls together certain things that are known at this point, that while the Commission continues to grapple with data sources and how to measure the magnitude of a problem or refine the problem or whatever, that there's enough information at this point to know that there's a problem. The whole world sort of reacts to the problem of access. The CMS regulation is its own evidence about access. The MUA/HPSAs are evidence of access problems. Because of the way that poor people are distributed into geographic areas -- I mean, we could go on and on and on with the fact that we know enough to know

that there are some significant access issues, and that there are --

CHAIR ROWLAND: Sara, just a clarification. You're talking about access issues broadly, not just Medicaid access issues.

COMMISSIONER ROSENBAUM: I am talking about the sources of information on access problems that we know disproportionately affect Medicaid beneficiaries. In other words, I feel as if we've sort of been caught in some loop for a while now in the sense of trying to prove the existence of access problems, and Medicaid came up with an early-warning system for knowing that we have access problems in Medicaid, and my continuing feeling that we already know that we have an access problem in Medicaid, and that, in fact, just the existence of HPSAs and medical under-service area designations and the distribution of poor people into those communities tells us that we have the kinds of conditions going on that lead to access problems.

CHAIR ROWLAND: But I guess I was asking, if we're looking at it as there's an access to care problem for low-income people who live in certain communities, and then does Medicaid make that better or worse.

COMMISSIONER ROSENBAUM: Well, I think there are two issues.

CHAIR ROWLAND: So what's the cause? I guess it's how do we get at the cause of the access problem.

COMMISSIONER ROSENBAUM: Well, we're ongoing, and I mean, it sort of struck me hard enough so that I'm not being as articulate as I need to be, is that we should be able to construct a short and interim report -- and "report" is too fancy a word; that's why I'm thinking of a letter or something -- that shows the low-income access problem, shows that areas that have low-income access problems are also disproportionately where we find our Medicaid beneficiaries, that Medicaid does make a difference when you are dealing with access problems. We know that as well. And we also have some knowledge about

interventions in organization financing delivery that seem to mitigate or compensate for access problems, everything from the introduction of developmental resources like a community health center program or the capital investment in a safety net provider to the National Health Service Corps and comparable state programs, whatever we know from the evidence, so that we begin to convey the knowledge base that exists at a crucial time when we are debating -- we're going to start a debate in the country in a few months about how much, if any, Medicaid funding that we withdraw from these communities, because -- and, of course, this has been a big issue for me for years, that Medicaid, of course -- and I say this as a lawyer. Medicaid is an individual entitlement, to be sure, but Medicaid needs to be understood as an ecological program. It is the infusion of resources into communities that suffer from access problems. And even though we can't always tie it to specific beneficiaries, although we have HIS data and other data, at some point Medicaid needs to be understood as a community intervention in its own right, and that when you combine Medicaid with other kinds of interventions, you begin to see an abating or a mitigation of access problems.

And so while I think we -- and I think we need to say that we are continuing the effort to try and refine the information we give Congress about the magnitude of the problem, how Medicaid makes a difference, and interventions that would help. But I'm feeling as though we know a lot as a Commission about the fact that there's a problem that Medicaid plays an important role in mitigating the problem, and that particularly when you combine Medicaid with other kinds of interventions. And maybe I'm feeling the pressure of it because of the kind of debate we will have at the end of the year.

So I was struck by it in listening to Lois, you know, thinking about what we don't know, that we actually do know a fair amount.

COMMISSIONER GABOW: I'm not going to be as radical as Sara. I was going to say that just three other data sources that may be useful, just sort of mundane, poison centers actually because they're national, they are collecting -- we run the poison center for a bunch of states, and the data that gets collected

from them is more robust than just poisoning. So I think looking at some of their data would be useful.

I don't know if every state has a Medicaid advice line.

COMMISSIONER ROSENBAUM: Advisory committee [off microphone].

COMMISSIONER GABOW: Advice line? But the advice line, our advice line gets about 100,000 calls a year, and that's just for us. But the nature of the call -- I mean, maybe if you could get information from a group of them, the nature of the calls, the volume of the calls are a surrogate for a different point of entry. So if you don't have co-pay, if you don't have transportation, this is great, and we give our prescriptions on our line. So its use and what it's being used for would be, I think, another interesting source of data.

The third thing, I don't know how many safety net providers have these. You may know this, Sara, for FQHCs, but the single biggest early-warning data that we've acquired over my years at Denver Health is once we created a centralized appointment center for a whole enterprise, because people used to have multiple points of entry, so we actually never knew who was having a problem getting in or where they were having a problem or by payer type. Now we keep all of this data by payer, by duration, that they're on the list, et cetera. So if there were -- which I don't know -- that kind of centralized appointment center at sort of key Medicaid providers, it's a great early-warning sign, because we had a clinic, we had a provider, you could see the wait list go down. I mean, it's very month-to-month sensitive. But I don't know -- I just don't know how robust that is across the country, but we do know that there are few other safety nets that use that.

CHAIR ROWLAND: Well, we also know that one of the incentives going out there for accountable care organizations and for all of the provider reforms is electronic medical records, it's centralized data information. So we should really be looking at that as the future direction as well.

VICE CHAIR SUNDWALL: One other data source that may be useful is the all-payer claims

databases. We have one in Utah that can give you geographic utilization anywhere in the state, and that could be a big help. I know they're not everywhere, but we have one that's complete and working well.

I just want to follow up on what Sara said. I had a flashback back to our first meeting, I think in September when we first convened. We can't whine about what we don't know. I think we need to acknowledge that there are access problems based on the information we have, but I think if we go up there -- or our report reflects the dearth of data or insufficiency, that won't sell well. I think that we have enormous data sources. They're not perfect, and there are gaps, certainly, but I think it would look very bad for the Commission to highlight the deficiencies in data instead of identify the problems in access that we are aware of and, you know, not shy away from mentioning data needs. But that should hardly be the focus of our report.

COMMISSIONER RILEY: Just to follow up on David, I have another point -- in Patty's style, I have 17 points.

[Laughter.]

COMMISSIONER RILEY: The interesting thing about the all-payer claims database is it's not -- there are issues of attribution. So increasingly, as physician practices become part of hospitals or merge, you know that the claim came from a practice, but you don't know much about -- you can't attribute it to an individual provider.

VICE CHAIR SUNDWALL: We've got the Medicaid data in there [off microphone].

COMMISSIONER RILEY: But without the Medicare, with the Medicaid -- that issue of attribution is an important one because you don't really get the level of detail about really what providers are doing around access. So it's at least a flag in our worry column.

But my bigger concern, which I always raise, is I worry -- I think if we go Sara's direction and show, you know, that still Medicaid is -- matters, that Medicaid matters in low-access areas, throughout this the

question of access to what. These tools are such blunt instruments, and I'm so worried that we're going to spend all this time measuring yesterday when we know we have a service delivery system in flux, we know we have 2014 coming, and the bigger questions are access to what's appropriate service, how much of the access problem is variation, inefficiency, overuse, and how much of it is too few providers. And I think if we don't get to that level of sophistication in our analysis, we've done a disservice to the question of what is access. And maybe tomorrow we can get into it a little bit more, but I really worry about measuring the old way, the old stuff, and losing the point about appropriateness and, you know, what is it that we're providing access to.

COMMISSIONER ROSENBAUM: Well, I think actually -- I mean, you say it very well, and it's part of my concern, is that we have a given on the table, and the given on the table is certain preconditions that make for inadequate access to things that are good and potentially overuse of things that are not good. And either way you cut it, that's an access issue. I mean, it's also a quality or an appropriateness issue, but it's an access issue, and I am very eager to see the Commission, with its considerable resources and knowledge, to start moving over to the side of what do we do about the problems we've got. And I'm just trying to think about some way to get out of this sort of effort to prove that a problem exists when we kind of all know that there are problems that exist. That's all.

COMMISSIONER RILEY: Maybe it's more on the payment side [off microphone].

COMMISSIONER WALDREN: Just two quick points, one on claims. There's a rendering MPI and a billing, so we wouldn't know who's rendering the service. And then the other point was you mentioned about centralizing data and EHRs, you know, I wouldn't hang your hat on that because they're not going to be designed to provide that type of data. So maybe one thing, if we want to think about EHRs, we should really think about what do they really need to do, what data do they need to capture, how they need to be structured to get some of these things out, because there's not going to be a magic bullet

that will just get us the data.

COMMISSIONER CHECKETT: One of my, I guess, great fascinations with Medicaid through the years has been how disparate the populations really are and that, you know, you simply can't say Medicaid and really say anything that's really in depth because it's, you know, poor kids, it's kids with disabilities, it's -- we all know the long, long list.

So to the extent that in our wish list of things we're saying that we would like Lois to work on, I think we would have very different conclusions on access if we really broke down and separated out, for instance, poverty with families or individuals on Medicaid who are on because of a health condition or a disability. You know, some dual eligibles have terrible access problems because they're really poor, and some duals have just spent down their money and have really affluent, educated kids who are working the system, and they don't really have access problems.

I don't know how you drive that, but I think there are tremendous variations within access for people on Medicaid, depending on how they got on the program. So my comment. It would give us, I think, a richer understanding of what we're really dealing with, and it might be even looking at things like geography, because I think when you get into like a rural/urban concentration, you've got one set of access problems that are very, very different for others who are getting onto Medicaid because of a different issue, whether it's renal failure or -- you know, the list goes on.

CHAIR ROWLAND: I think we also have to recognize that in 2014, if the expansion goes through, we'll have a whole new population of low-income adults that are on Medicaid who have never been on Medicaid before, or who may have cycled through at one point, but have not been eligible for a while, new contact.

COMMISSIONER CHECKETT: Right, and just to add --

CHAIR ROWLAND: Who are probably already at Denver Health as an uninsured patient, and

now how do you move them and enroll them?

COMMISSIONER CHECKETT: Right, right.

And I think, you know, one place for us to go at some point -- and Trish or Patty mentioned it -- is that we have an access problem, but how much of it is to say there's an access problem because there's not enough providers? And I think we're going to have to get to that, because I think that will be a really big issue.

When you don't have enough pediatric dentists, for instance, at all, then to throw Medicaid at $12 for a visit, well now you've really got a problem. But you actually had a problem even before you added Medicaid in.

So I think that's something else we need to get to.

CHAIR ROWLAND: It's also interesting, at one point in discussions with the children's hospitals, they talked about the lack of some of the pediatric specialists, and said people don't go into training for some of these specialties because they know that the reimbursement rates are going to be so low under Medicaid and Medicaid is such a dominant payer for pediatric care.

In Montana, I know that Baucus' staff cites that there are often just one specialist in the entire state who could take care of some of the specialty needs.

UNIDENTIFIED SPEAKER: [off microphone] Or no specialist.

CHAIR ROWLAND: Or no specialist.

This chapter that we're working on also goes along with a background report that was prepared by CaMRI that looked at -- remember, we commissioned them to look at what kinds of data might be out there for an early warning system and what some of the limitations are. So this is an overview chapter that will then have that as a technical report also posted on the website?

It was done -- Cathy Hoffman, Andy Bindman and the California Medicaid Research Institute.

Other questions?

Lois is going to make up a lot of data for us -- I mean, I think that one of the other issues that comes up and that we might want to raise in this is really the difference between administrative data, which is not actually mentioned here, and survey data and other information sources, and the challenge -- just so that people recognize our challenge versus that of MedPAC -- of having 50 states with very different environments in which their provider community operates, different payment policies, and different access issues. And that again, going back to our discussion a panel before, is why sometimes national numbers obscure what are real differences within this program.

VICE CHAIR SUNDWALL: Quick question for you inside-the-Beltway folks, I just got an e-mail last week saying the Secretary had announced a major move toward a uniform claims processing form. Are you aware of that? Or what does that mean for us? It seemed like a monumental -- maybe she just has good PR people, but it sounded really like a bit shift towards a uniform electronic claims form.

COMMISSIONER WALDREN: Did it say -- was it 50/10?

VICE CHAIR SUNDWALL: I don't remember, 50/10. But you didn't think of some seismic event last week with --

COMMISSIONER ROSENBAUM: It wasn't in La Monde, I can tell you that much.

[Laughter.]

VICE CHAIR SUNDWALL: Okay, I'll try and find the e-mail and send it to you.

COMMISSIONER ROSENBAUM: [off microphone] It sounds like it would be a big deal.

VICE CHAIR SUNDWALL: Yes, it sounded -- our IT people at Utah were quite pleased. They thought it was a move in the right direction.

CHAIR ROWLAND: Maybe because of the electronic records?

COMMISSIONER ROSENBAUM: [off microphone] [inaudible].

VICE CHAIR SUNDWALL: I will check and send it to you and then you can tell me how profound it is or isn't.

CHAIR ROWLAND: Judy, you had a comment?

COMMISSIONER MOORE: I just wanted to say the obvious, which is I sat and listened to the ASPE people talking about all of their measurements of access and I trust that everybody is all talking to one another and paying lots of attention there, because it's too bad when you've got lots of resources there being spent on it and lots of resources that we have without making sure that we're not doing too much duplication. I know they've been involved in some of this for a while.

And similarly, the whole situation in California with the requirements that CMS has worked out with California to monitor access in light of their payment cuts -- I mean the California payment cuts -- is interesting to me. I'd like to know a little bit more about it, just from the general standpoint of have they set up, as CMS set up and organized some sort of a construct that's very specific to those problems in California? Or is it something that will be useful across many states, looking forward, around monitoring access when changes are made in payment policy or maybe when changes aren't made in payment policy.

So those two things, I just wanted to make sure we've got the other Federal activities on our radar screen and we know a lot about what's going on with them.

CHAIR ROWLAND: Okay, great.

Thank you, Lois. Let's take a 10-minute break and reconvene to talk about MACStats and more data.

[Recess.]

CHAIR ROWLAND: So, everyone, David has gotten clarification that the issue he was talking about was a release by Secretary Sebelius of a proposed rule that would establish a unique health plan identifier under the Health Insurance Accountability Act of 1996, known as HIPAA. Okay?

I think we have been so delighted today to discuss data that we surely would like to spend the remainder of this meeting talking about MACStats and maybe, April, as you go through the MACStats presentation, you could reflect back on a comment earlier when we talked about trying to see if there were data items that we could pull out to tell a little story or to develop more of a way of communicating snapshot information that would make the tables more digestible to those that don't like skimming pages and pages of tables. But you should know that everywhere we go on the Hill and with others, having this data pulled together is always the first thing people say in complimenting the work of MACPAC.

REVIEW OF MACSTATS, JUNE 2012

MS. GRADY: Thank you, Diane, and as I go through the presentation, I will highlight some of those areas where we might be able to tell a little bit more of a story.

Today -- I apologize. We've got animation in here. If Matt could actually come up and help get this back on track, that would be great.

I'm going to talk about two things today. Obviously, the first is the proposed MACStats that we're discussing for the June 2012 report, and I'll also touch on at the end of the presentation some issues to consider for our longer-term data strategy and some of the things we've been talking about today.

In the proposed MACStats for June 2012, the tables and figures would largely follow the order and the content of our June 2011 report, and in the Session 5 Tab in your materials, there is a table of contents listed there that's pretty lengthy for you to review at your leisure. We won't go through every single table today, but we'll hit on some of the major issues.

One of the things we plan to do, which you can't see on the screen right here for some reason, is to emphasize key findings in each section for readers, so along the lines of telling more of a story that's missing from the screen right now.

CHAIR ROWLAND: Is that missing because you think it's hard?

[Laughter.]

MS. GRADY: Not at all. Not at all. I just wanted to add a little element of mystery.

What we did, we did last year have the June MACStats broken into sections where we had a little bit of an executive summary up front attempting to digest the tables that follow, but I think we could do a better job in being a little punchier and maybe even having an executive summary of the entire MACStats so that you don't have to go section to section to find a little bit of the story line.

In addition to emphasizing the key findings in each section, we do plan to provide some additional breakouts of enrollees who are dually eligible for Medicaid and Medicare and separating out those with Medicaid-only coverage. On a number of occasions in today's meeting, we've talked about connecting things back to our March report on persons with disabilities, and so this would be an attempt to do that to put some of our statistics in the context of the dual-eligible population and folks with Medicaid-only coverage.

Moving on to provide a little more detail on each section in the June 2012 MACStats, we're proposing to have six sections, and I'll go through each one of these individually and talk about the major data sources that we use in that section and also the key point or some of the key issues that we'll emphasize in those sections.

Section 1 is dealing with trends in Medicaid enrollment and spending, and what we have here is historical data compiled by CMS going back to 1966 and bringing it back through to the most current information, which is fiscal year 2011. We've talked extensively about the data sources that are used in this table, these figures, and that's the Medicaid Statistical Information System and the CMS-64. And the main point that we have in this section here is that growth in Medicaid spending and enrollment has varied a lot over the years. There have been some periods where enrollment and spending growth is more flat, and then some years where you see some big spikes in spending. For example, in the early 1990s, there was a

real step increase in Medicaid spending. During some of the recession years, you see pretty big increases in enrollment. So we can talk a little bit about those trends. That might be part of the emphasis on the story, what you're looking at in the Medicaid program, there are kind of eras of Medicaid spending and enrollment.

The other big issue here that we emphasized in the March 2012 report on persons with disabilities or the chapter on persons with disabilities is that enrollees qualifying for Medicaid on the basis of a disability account for a substantial portion of spending growth in the program, and that's over a long period of time, since 1975. We had the information going back that far, and persons with disabilities account for about half of the increase in Medicaid spending. They're a substantial chunk of growth in the program.

We don't have that broken out right now by folks who are dually eligible versus those with Medicaid-only coverage, but that is an analysis that we are looking at and would like to have some information on in the future. But right now we have persons with disabilities as a whole.

CHAIR ROWLAND: And, April, there's no way within that to get from this source or any other source those who are in the waiting period for --

MS. GRADY: There is nothing in the Medicaid --

CHAIR ROWLAND: That goes to the point I think Andy raised a while back about the disability chapter.

MS. GRADY: There's nothing in the Medicaid administrative data by itself that would indicate who is in the waiting period, but when I talk a little bit later about our future work using the merged Medicare and Medicaid data, this is something we'll look into, but I do understand that the Medicare data does have information on your original entitlement for Medicare. So we may be able to sort of get back door at that issue and look at people who were in the waiting period at some point in time.

COMMISSIONER GABOW: Since this trend line is going to go over such a long period, I

wonder if there will be utility putting arrows for certain key events along the way that, you know, expansion, recession, whatever, so that you could put some context to the line.

MS. GRADY: John Klemm from the Office of the Actuary at CMS published an article several years ago that did exactly that. So we could revisit his work and see, you know, extending that out for the more recent years that weren't covered in his article. But that is certainly something we can look at.

If there aren't any other questions, I'll move on to Section 2, which looks at the health and other characteristics of Medicaid and CHIP populations. We've talked a lot about this today in the discussion of the access to care chapter and the fact that when you look at the characteristics of Medicaid and CHIP enrollees, for example, their health status, their diagnosed conditions and demographics, they are different from folks with other types of coverage, and that's one of the things that we try to control for in our analyses of access to care.

What this section of MACStats is doing is essentially providing the detailed comparisons, unadjusted comparisons that might be useful, again, providing context for that access to care analysis that we have so that you can see all of the things -- many of the variables that we're controlling for in this other chapter. It's sort of not discussed in that context, but it does provide information that would be a helpful supplement to that chapter perhaps. Again, this is using National Health Interview Survey data.

Section 3 of the June MACStats we're proposing to look at Medicaid and CHIP enrollment, and specifically here we're proposing a new analysis that combines several data sources, and that includes 2009 census data on the total population, U.S. population by age, and then using that as a basis to examine what portion of the people in each age group is enrolled in the Medicaid and CHIP program. And what we know from other analyses is that when you look at the child population, a much larger percentage of the U.S. child population is enrolled in Medicaid and CHIP compared to the adult population, either 18 to 64 or age 65 and up. And this is something that we will expect to change over time. You know, if the 2014

expansions take place, this is something that we could look at trends in over the years. But we'd be starting with 2009 data at this point.

This section would also have our standard table showing Medicaid and CHIP enrollment by state, broken out by various characteristics such as basis of eligibility and dual-eligible status.

Section 4 --

CHAIR ROWLAND: You know, April, it might make some sense for the Section 3 data to show these numbers by family type, so you've got children, you've got adults with dependent children, and adults without dependent children, so that we have a marker that we can then look at post-2014.

MS. GRADY: Yes, I think --

CHAIR ROWLAND: The census data allows you to do that.

MS. GRADY: Yeah, the only sort of hesitation I'm having is that the way that you're categorized in the Medicaid administrative data in terms of your basis of eligibility -- I'll use the example of someone who's a parent. You can be eligible for Medicaid on the basis of being a parent, but that wouldn't give us a complete picture of all people on Medicaid who are parents, because if you're a person with a disability, that might be your pathway to Medicaid. So we'd have to think a little bit about whether we could do an apples-to-apples using the census data and the Medicaid data. But that's something we can think about.

VICE CHAIR SUNDWALL: Can you get single-parent data?

MS. GRADY: We cannot from the Medicaid administrative data. That is something that might be available from the survey, the census data.

Okay. Looking at Section 4, which deals with Medicaid benefit spending, again, here we're using MSIS and CMS-64 data. We've talked a lot about these sources over the past year and a half. What we show here is that the mix of spending on different kinds of services, for example, acute versus long-term care, differs greatly by subpopulation, and that long-term care users account for a very small share of

Medicaid enrollees, but they're driving a majority of Medicaid spending. And here I think we could, you know, in terms of telling a story, draw this back to, again, the discussion of persons with disabilities in our March chapter, talking about the role of Medicaid with regard to long-term care in particular, and then differences between those who are Medicaid-only and those who are dually eligible, Medicaid playing a different role there in terms of the spending.

Last June, we also had a section on Medicaid managed care in MACStats, and this was in the context of our June report, which was entirely focused on various aspects of Medicaid managed care. So we're proposing to keep this section again this year and update the Medicaid managed care enrollment numbers that we had. And I think given that this year's report does not have a particular chapter on Medicaid managed care, we can sort of beef up the front end and the description of Medicaid managed care and the role of managed care in the MACStats section itself rather than in the text of the body of the report itself.

There's two main data sources here: the Medicaid managed care enrollment report and the MSIS data that we use for various analyses. And one of the things that we pointed out last year is that there are various service delivery models that might be referred to as managed care, and that ranges from a comprehensive managed care organization to a limited benefit plan that might only provide dental, transportation, or behavioral health benefits and primary care case management models that CMS does also refer to as managed care in some contexts. So, again, telling the story that the percentage of enrollees in managed care sort of matters to understand what model you're talking about and who's describing that model as managed care.

All right. Then the final section that we propose for the June MACStats is a technical guide, and in the interest of not forcing folks to page through, you know, long methodological discussions that they may or may not want to read, we've sort of contained the --

CHAIR ROWLAND: Patty would like to read them all.

MS. GRADY: I'm sure Patty will love Section 6 of the June 2012 MACStats. Put her right to sleep at night. But here is where we get into some of the nitty-gritty details that certain folks out there really do appreciate us being transparent about the methods that we're using, the data sources, how we're making adjustments when we do, and so here is -- we sort of put that all in one place.

Some of the major sections and issues that we talk about here are how to interpret the Medicaid and CHIP numbers, and this seems really basic, but it's helpful in some ways to understand what you're looking at, even just the number of people who are enrolled in Medicaid and CHIP, it matters whether you're talking about the number of people who are enrolled at a point in time is much a smaller number than the number who are ever enrolled in the program during the year because of the churning that takes place. And so when you're looking at a chart, it's helpful to know which one of those statistics is being provided. So we had a little discussion of that.

We also talk about adjusting the benefit spending data because one of the things you've heard about from me, probably more times than you want to, is the fact that some of the data sources on spending don't quite line up. And so what we do is we make the best adjustments we can to provide comparable information about states, and this is one of the issues that Diane raised with the administrative data. You know, CMS tries very hard to get standardized information from the states, but, you know, there are reasons why that's not always possible or easy to do. So what we wanted to do is make sure we're presenting apples-to-apples information across states in the best way that we can. So we talk about that.

And then as I just mentioned, there are different definitions of managed care and sources of information on that particular issue, so we talk about that to make the readers understand that, again, what number are you looking at, what does this contain, and who's included.

Okay. So I sort of walked through the proposed MACStats really quickly, and so let me pause here before I move on to talk about sort of our broader data strategy issues.

COMMISSIONER RILEY: I just wonder -- it's hard to sort of visualize, but I wonder if in Section 1 there might be a way to do something a little bit more targeted on what the cost drivers are in Medicaid so the reader understands that these are the three biggies, and if we could do it historically over time, that would be fascinating. But it just seems to me that's a message that we ought to drive home and call it cost drivers.

MS. GRADY: The area where we do have a little bit of discussion is we try and break it out into increases in enrollment versus increases in spending per person, so how much of this is about new people on the program versus increases in the benefit package or medical costs and other factors. So we do have a little bit of that, but we could augment that.

COMMISSIONER GABOW: One thing I wonder, to begin to sort of elucidate that point, if the data permits you to look at both the absolute number and rate of hospitalization of this population over time with and without delivery in there, and also whether there's data about the top ten diagnoses for either the population globally or the reason for hospitalization. My guess is that's changed substantially over time, but I actually don't know that, and it might be useful. It also might indirectly get at access.

CHAIR ROWLAND: You might actually want to do that for children versus adults, too, the top ten, because the adult population is so skewed.

COMMISSIONER ROSENBAUM: The only other thing -- the other thing that was on my mind watching this, and, of course, seeing the MACStats and then the technical guide to the MACStats -- is whether because the MACStats are so rich and we are very correctly, I think, providing all the backup we need for people who are deep into the data and want to understand how we derive our numbers, I'm wondering also if we need to do something for people at the other end of the spectrum; that is, of the five sets of data we are giving people, what are the most important takeaway messages we have for them from the data? And there may be sort of a highlights that would be quickly accessible to people. I realize there

are so many important messages in these data, it's hard to make a choice. Nonetheless, I think -- and I realize also in choosing we are, you know, shaping a message. But I still think there's so much information here that as a Commission we ought to decide what the things are that we really want people to understand from these data.

COMMISSIONER MOORE: On this last point of storage analysis and management, I know that Penny Thompson is continuing to work internally -- and I know this is slightly off topic, but not really, maybe not really. Anyway, is continuing to work with states and internally in CMS on quality, accessibility, more standardization and so forth, and I for one would love to have some more information about where they are, how far along. Maybe that's for our retreat in the summertime or whatever, but I would like to make sure that we keep up to date with that and have an opportunity to interact with the CMS people who are concerned about that, because long term it's just a huge deal, I think.

CHAIR ROWLAND: That's a great point, and I think, April, that puts you back on your slides.

MS. GRADY: It does, and I can come back to Patty's question about hospitalizations also. That sort of works with what I'm going to talk about here.

So, in addition to our sort of routine MACStats, which make use of, you know, several key data sources, we wanted to talk with you about a longer-term data strategy that we'll be developing over the next few months, and we wanted to start that conversation now to get your input about additional needs and directions we might take. And I know this is a bit ironic to say since we've focused the entire day on data, but, you know, they're not the only component of the work that we do here, but they are a key component. And so one of the things we want to do as a still small and relatively new staff is build our capacity to think about issues and be ready to analyze them in response to your needs and desires. So, for example, Patty's point about hospitalizations and diagnoses, we'd need to go to new and different data sources to look at that information, but it's something that we're planning to do.

So, obviously, there are sort of overarching issues of access, payment, and quality that we want to address when we think about this strategy, but then we also want to be ready for the analysis of specific topics or policy questions that you or others might have as we go along here.

The sort of not terribly exciting but very important issue that we need to think about in terms of storing and analyzing and managing the data that we do have is something that we as a staff are thinking about as well.

With these issues in mind, I just want to talk briefly about some of the specific areas that we plan to work on in the near future or are working on right now, and I'll start by talking about Federal administrative data, which is one of the things we focused on a lot to date.

One of the issues that you heard about today are the merged Medicaid and Medicare data, and specifically we're working with the Medicaid analytic extract data, the MAX data, and various Medicare data sources including the Beneficiary Annual Summary File. And what's different about this MAX data source is that we can go to a deeper level of analysis than we have currently with the MSIS data that you've seen and that we've used in the MACStats and our chapters to date. What this allows us to do is to go down to a finer level of detail to look at claims, to look at the specific services that people are receiving, the diagnoses, and a lot more detailed information than you've seen to date. So this will be, I think, a useful exercise.

And as Melanie Bella mentioned earlier, we've had a number of conversations with CMS and with MedPAC to understand how they've used these data in the past and how we might coordinate with them on methods and other issues in the future. So we're actively working on this right now.

Another area where we might be making greater use of the Federal administrative data is with regard to drug utilization and spending, and there are a number of Medicaid data sources there. We're also looking at Medicare Part D data for our dual eligibles analysis.

As Diane noted, administrative data are just one source. We also have surveys, so I'll talk a little bit about some of the work that we're looking at there.

We last year had a contractor look at some of the access to care measures in various surveys, and that includes surveys of households, but also eight surveys of health care providers. These are both federally sponsored and privately sponsored surveys. So we began this work last year, and we anticipate issuing a report from our contractor with this information at some point, and we'll discuss that with you further before that happens. But that's one thing we're working on.

And the other issue we discussed in potentially using data from individual states rather than federal sources, and I think both Rick Kronick and Melanie Bella both made reference to the need for non-federal data sources on Medicaid for various purposes, sometimes because the federal data sources don't have the information or because they're not available in a timely manner. So there may be some instances where we want to check in with the states on different issues, and some of the discussions we've had potentially around maternal and child health, the primary care payment bump, managed care encounter data, and all-pay claims databases are some examples where we've thought about some of the potential uses of non-federal data sources.

So that sort of brings me to the end of the presentation, and I look forward to some feedback from you both on the MACStats if you have additional questions and on our data strategy more generally.

COMMISSIONER GABOW: Regarding data sources, I do think we should point out or think about the richness of the managed care data from the managed care companies, and that we are letting this huge, robust data not be utilized. We may not be able to get ready access to it as a Commission, but sort of I think just pointing this out that this is a rich data source that we shouldn't ignore.

Under the drug utilization and spending, I think one of the issues that may deserve some attention at some point is the 340(b) pricing versus the rebates or and the rebates -- I don't know whether it's an "or" or

an "and." But 340(b) is once again under attack, as it almost always is, right, with DSH. They're always together. But without 340(b), I really think that the pharmaceutical availability for the Medicaid patients would be drastically reduced and, hence, the outcome measures would be -- like control of hypertension, control of diabetes, would be bad.

The other thing, which maybe isn't so important for Medicaid but is important for the uninsured, is the indigent drug program that PhRMA runs, but I just think maybe as we think about drug utilization there are a set of things that these special funding mechanisms which make medication available and then the issue of formularies, which I also think is important, and we're a big believer in tightly controlled formularies, but that whole discussion I think has importance for this population.

CHAIR ROWLAND: Denise?

COMMISSIONER HENNING: And to Patty's point, one thing that I found was that if I prescribe a drug, that actually bumps up the level of the office visit, versus if I advised for them to use an over-the-counter medication. Now that's a perverse thing to me.

So I can tell them to take two Aleve twice a day, or I can give them a prescription for naproxen. I get paid more if I write that prescription for naproxen. That does not make sense.

And there are very few programs that actually pay for any kind of over-the-counter medications, except Integral, Donna's Medicaid arm. But there is just so many ways that we could actually be saving money. If I tell somebody to take calcium with vitamin D, I get nothing. If I write them a prescription for a prescription form of vitamin D, that bumps the level of my visit up.

So all of that kind of thing, it doesn't make sense. It's costing us money. And I think that we need to start looking at putting a little sanity into those kinds of incentives.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: First of all, I think it would be fascinating actually for us to

take a number, going back to Patty's earlier point also, to take a number of common diagnoses where there are options to go over-the-counter appropriately versus a prescription to be able to demonstrate for certain standard diagnoses what the consequences are of sort of intensifying the technology by requiring a prescription when an over-the-counter would be appropriate.

Which brings me to my second point, and that is whether -- I mean, one of the things, obviously, that's a huge driver in health care costs is the introduction of new technologies without control. And the question is whether there's any way in Medicaid to capture this.

For example, obviously drugs is an example. But devices. I'm thinking about whether there's any way that we can deal with the Medicaid market in assistive devices, the Medicaid market in more advanced technologies that are really important for people with disabilities, but looking again at the question of how Medicaid -- it ought to be affected, actually, by this because of the high use by people with disabilities. But I don't think it's well understood. There are certain disputes that have sort of brought it to the forefront, whether it's a treatment technology or an FDA-approved technology.

But I think we would be doing some -- we would be adding to knowledge about Medicaid to be able to look specifically at Medicaid and new technology.

I just have no idea whether there's any way to do that.

CHAIR ROWLAND: Also, a number of years ago there was a survey done of the top 10 prescriptions or prescribed drugs in each of the state's Medicaid programs, but it was done before the Medicare drug benefit kicked in. I do remember psychotropic drugs were really at the very top there. But it would be interesting to even just know, in different states, what the most commonly used drugs are.

COMMISSIONER GABOW: Sara's comment, I think, is really fascinating because I think you could develop two different hypotheses.

My hypothesis would be that the technology has driven the cost of Medicaid much less than it's

driven the cost of employer-based insurance and Medicare. And pointing that out might be very interesting, just in the way I see our population cared for.

COMMISSIONER ROSENBAUM: No, I think technologies diffuse, potentially, more slowly in Medicaid than they do in other forms of financing but I don't -- you know, we have no way of knowing.

CHAIR ROWLAND: I don't know, it probably depends on some of the interests at the state level, in terms --

COMMISSIONER ROSENBAUM: [off microphone] That's just it [inaudible].

CHAIR ROWLAND: She's just saying we'd be informed in either direction.

Mark?

COMMISSIONER HOYT: I'm thinking about the aspects of long-term care data strategy. This is more of a question at the moment.

The Medicaid program is just so expensive, there's no getting around that. I'm sure there's people of a certain persuasion that are not compelled by anything except the absolute dollars going down. But not a new issue really, and we consulted the states -- still do -- for years. You're looking for some other barometer, something to compare against, that would maybe cast Medicaid in a better light.

We always used to look at the state employee plan because you've got a lot of people in a gigantic, uniform benefit plan, in the same geography. Medicaid frequently, in terms of a rate of increase or cost per person, came out much better than the state employee plan, even taking into account changes they would make in cost-sharing or other things they would do to try and control utilization.

So I'm wondering, you know, is there some other kind of macro-level data that we could get at without a humongous effort to produce some similar type of result? I don't know what the Federal Employee Benefit Plan looks like, or whether you could get some more state employee benefit plan data, but it seems like something that probably might be working taking offline or some way to go fishing for

another acceptable statistic.

But if you could at least cast it in a little bit different light, maybe turn the thinking around where they look and go "huh, wow, really the rate of increase isn't that high, compared to ESI" or something else we could bring out. I'd like to see us think some more about that.

CHAIR ROWLAND: Which obviously interacts with the physician payment levels. April, what do you think?

MS. GRADY: I was just thinking of some statistics that I think the Office of the Actuary at CMS puts out regularly with their NHE statistics. I'll go back and review those. But I think what they've tried to do is look at comparable services.

Because one of the issues in doing that kind of analysis is controlling for differences in the benefit package, which is something that's come up a couple of times. And so comparing like to like, looking at just hospital or just physician services. I think they have tried to do some of that analysis and we could go back and review that.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: When you're talking about long-term strategy and data management, is that costly? Does that take much of our budget? Or is that not an administrative cost, significant?

EXECUTIVE DIRECTOR ZAWISTOWICH: It's somewhat expensive but I think it's a critical piece for what we have to do in terms of developing our capabilities long-term.

CHAIR ROWLAND: So the answer is yes, it's expensive.

VICE CHAIR SUNDWALL: [off microphone] You're so politic.

CHAIR ROWLAND: Well, and I noticed that Lu answered it, instead of April.

Any other questions? Comments?

Okay, thank you, April. We will spend the money and get a good database going.

Now we would welcome any comments from the public that has endured our data discussion all day. We appreciate your being here. I don't see a mic but if anyone has a comment they'd like to make, please rise.

PUBLIC COMMENT

[No response.]

CHAIR ROWLAND: Okay, well, I think you've gotten a preview of where we would be headed in our June report, but also I hope a preview of the longer term work that we plan to engage in will try and really focus on building a research agenda. We've talked a lot about getting out more than -- instead of just two big reports a year, trying to get out shorter pieces, even maybe getting out a little bit of a blog on different highlights of different things we're doing because we really want to make the information that the staff is gathering and preparing for us to be as available on a timely basis through the website to others.

And we would appreciate any comments from you who try to use our work and who listen to the discussions here about e-mailing and sending us either notes, even if you don't come and make public statements, about what would be more useful or about other ways in which the work of the Commission could be facilitating a broader discussion about the issues and challenges and options and going forward with improving the Medicaid program, looking at the future of the CHIP program, and obviously -- dependent on where we are after the Supreme Court decision -- going forward with the Medicaid expansion and other delivery system reforms envisioned in the ACA.

So we welcome the comments of the public to help inform our work and we thank the Commissioners to spending the day on data. I was thinking maybe at the next meeting we would prohibit the word data from being mentioned and see how we could get through the day.

Our next meeting will be....

EXECUTIVE DIRECTOR ZAWISTOWICH: May 22nd.

CHAIR ROWLAND: May 22nd. At that meeting, we do plan to -- we've invited Gilfillan from CMMI and also Ed Salsberg from HRSA, to come talk about both the work going on in the Innovation Center a little more broadly than what is going on with the dual-eligible population, and also to really give us a fuller update on the shortage areas and the work going on to redefine medical shortage areas and how that can influence our work.

And then we will be finalizing the chapters for our June report.

So we stand adjourned and the Commission will deliberate tomorrow, as best they can, about what everyone wants to do with the research agenda. So I'm sure we'll have 1,000 ideas and then we'll have to figure out what we can accomplish within the budget, even though we know that the database is going to take a big chunk of it.

Thank you all.

[Whereupon, at 4:16 p.m., the public session was adjourned.]