MACPAC

Medicaid and CHIP Payment and Access Commission

Medicaid and CHIP Payment and Access Commission
PUBLIC MEETING

New Hampshire I & II
Renaissance Washington, DC Dupont Circle Hotel
1143 New Hampshire Avenue, N.W.
Washington, D.C. 20037

Thursday, December 9, 2010
1:37 p.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
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TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH
STEVEN WALDREN, MD, MS

LU ZAWISTOWICH, ScD, Executive Director

DAY ONE AGENDA PAGE

DAY TWO AGENDA PAGE

P R O C E E D I N G S [1:37 p.m.]

CHAIR ROWLAND: Good afternoon and welcome, everyone, to the third meeting of the Medicaid and CHIP Payment and Access Commission. We have a full agenda today in terms of beginning to look at some of the components of our March report to the Congress, to look at issues of access, to look at issues of payment, specifically to begin in this meeting to also look around at some of the issues related to dental care and to managed care. But we're very pleased to bring back Deborah Bachrach and ask her and the staff, as well as Kathleen Dunn, joining us from New Hampshire, to really kick off a discussion here about new directions for payment policy, some of the challenges and issues in payment policy.

Deborah is the president of Bachrach Health Strategies. Kathleen Dunn is the director of New Hampshire Department of Health and Human Services for the Office of Medicaid Business and Policy. Patti Barnett is our senior advisor at MACPAC, and Jim Teisl joins us as one of our payment experts at MACPAC.

So, with that, Deborah, lead us through your presentation, please.

PRUDENT PURCHASING IN MEDICAID:

CONSIDERING PARAMETERS FOR ACCESS AND PAYMENT

OVERVIEW

MS. BACHRACH: Thank you. I am thrilled to be back, one, because it makes me feel like whatever I said last time wasn't stupid; and, two, because since I was last here, I'm sure you have all read, as I have, story after story about state budgets and what that means for state Medicaid programs. And I continue to believe that getting payment right is a critical and immediate cost containment strategy. So for all those reasons, let me get going.

As we talked about last time, the overarching federal statute with respect to Medicaid payment policy is Section 30(A). It's summarized in the first slide, and basically it requires states to set their payment policies, their payment methods, and their payment levels so as to guard against unnecessary utilization, be consistent with efficiency, economy, and quality, and be sufficient to assure equal access to care. So, in shorthand, it's about access, quality, and efficiency, and that's the lens through which we need to judge our payment policies.

Now, the issue is, How do we give life to those requirements?

How do we actually know that our payment policies ensure some level of access, efficiency, and quality? And that leads us to what are the standards and what are the data that we should be collecting from states, because we can't figure out what data to collect if we don't know what the standards are. And so in the balance of my presentation, I want to look at what CMS has done, what states have done, and what federal courts have done to give meaning to the requirements of 30(A), access, efficiency, and quality.

There really is only one regulation that interprets 30(A), and that is the upper payment limit regulation, or UPL. What UPL does is it sets the maximum that states can pay for inpatient hospital services, outpatient services, and it separates outpatient hospital from outpatient clinic or free-standing clinic, nursing home, and intermediate care facilities for the mentally retarded. And in order to demonstrate compliance with the UPL, the state has to apply Medicare payment principles or what would Medicare have paid in the aggregate for inpatient services at public hospitals and in the aggregate for inpatient services at voluntary hospitals. So it's an aggregate number, and it focuses only on the payment amount. And the regulations that promulgated -- in the Federal Register promulgating these regulations, it said that the UPL requirement was intended to promote

economy and efficiency.

In reality, it is simply a blunt tool to assure that states don't pay in the aggregate for each of those institutional services more than Medicare would have paid. It does not look at are you paying too much for OB and not enough for detox. It doesn't look at anything other than in the aggregate are your payment levels below what Medicare would have paid.

In addition -- and this is very recent, "very recent" meaning within 2010. For the first time in the State Plan Amendment -- so every time a state wants to change how it pays, it has to submit an SPA, a state plan amendment. And for the first time we're seeing CMS ask questions about whether the payment change that a state is requesting is consistent with 30(A). And Katie can talk more specifically about this, but states are regularly seeing the kinds of questions that I put up there. Does this change that you're proposing -- and right now the change is frequently a reduction to payment rates. Sometimes it's a change in method. In either case, states get the question: Does this change allow the state to comply with the requirements of 30(A)? Or the other, has the state determined that the payments are sufficient to enlist enough providers? And so on and so forth. They mirror the 30(A) language, and they mirror some

of the language in the lawsuits that I'll talk about later on. There is no additional detail.

You're also seeing CMS be more sensitive to 30(A), for example, in the recent state Medicaid director letter that came out on the health home provision of the Affordable Care Act. And, again, it states that when you come into CMS with a state plan amendment to establish health homes, they will look that your payment methodology is consistent with the requirements of 30(A). Again, no additional detail.

While what I'm about to talk about now is not 30(A), it really goes hand in glove with the UPL requirements as something the feds spent a lot of time looking at, which is the process by which states set rates for institutional providers. And essentially what is required is that it be a public process with opportunity for stakeholders to comment on the -- it generally is the payment level. Again, no standard goes with it. It is simply a requirement that states use a public process and allow stakeholders to input on the rate proposals that a state is considering.

Now, let's turn to the states. You know, after talking to the MACPAC staff, we wanted to look at what are states doing to interpret efficiency, quality, and access. And, really, where states

have been out front is in their Medicaid managed care contracts. And the next two slides take provisions from state Medicaid managed care contracts that really do start to give us a standard for access, efficiency, and quality. And so what you see in managed care contracts between states and managed care plans are provider network requirements, access requirements -- what is the travel time to reach a primary care provider, to reach a hospital? -- appointment availability standards. I gave you a couple of examples: urgent care must be accessible within 24 hours, routine non-urgent care within four weeks, and so and so forth. And those are just a few examples.

Appointment waiting times, in the New York managed care contract it says patients may not be required to routinely wait more than an hour. And each of these requirements -- I know. How many times do we wait more than an hour? But it does say that. Some are more realistic than others, but, on the other hand, they are standards. And when we're groping for standards, this is the one place where I could really find some standards. And how much a state monitors these is critical because where a state is active in monitoring, you do see -- and I can speak for New York -- a real difference.

Also in the managed care contracts are data colleague requirements, both in terms of encounter data, quality data, and

financial data, and requirements about using evidence-based practice guidelines. So this is where, in putting this presentation together and really thinking about it, I found something resembling standards.

Now, if we go to fee for service, it's not as clear a picture, and it was difficult to find any standard for access, efficiency, and quality, so I broke it up in the best way I could. So we know the institutional rates by law have to be below the upper payment limit. I would pose the question as to whether that does anything to demonstrate efficiency or economy.

Physician fees are generally below Medicare levels, but I'm not certain that says an awful lot about inadequate access. I mean, we know Medicaid payments to physicians often in fee for service -- less so in managed care -- are below Medicare levels. That is a factor in access. I don't know that it is by any means dispositive.

Then we turn to payment methods and states vary widely. And many states -- and we talked about this last time -- continue to use flawed methodologies that were abandoned by Medicare and private payers literally decades ago. So that we have methodologies which encourage overutilization. If you pay per diem, if you pay per visit, the incentive is to have more visits and more days. Some encourage the wrong utilization. If you pay more for inpatient care

than costs and pay less than costs for outpatient care or for ambulatory surgery, you will have more inpatient admissions than is necessary, or where you could have done the surgery on an outpatient basis.

We know from the recent attention to potentially preventable readmissions that, to the extent -- or potentially preventable complications, when we pay more for complications and not less, we fail to disincentivize complications. And some discourage efficiency. Katie will talk more about this, but, again, if you pay based on institution-specific costs, there is very little incentive to provide the care more efficiently. And you will find that states vary all over the place with respect to payment methods.

So whatever the pluses and minuses of payment methods and levels, and to whatever degree we or I can be critical of states, including my own, I think it's important to note that all of these methodologies and levels go through a fairly rigorous state plan amendment review process and are approved by CMS.

For two reasons, federal courts are intervening in this area more and more. The first is because, faced with budget gaps, states are turning to rate cuts to bring their Medicaid costs in line with revenue; and, two, because there is no or very little federal

guidance, there is more of a role for federal courts.

The problem with leaving this to the courts -- there are multiple problems. First of all, the cases are, I think, literally all brought by providers. In a couple of cases, some of the consumer groups are co-plaintiffs, but the lead plaintiffs are all providers. And, therefore, the analysis is through the lens of the provider -- clearly, one stakeholder but not the only stakeholder. Taxpayers are stakeholders, states, federal government, and beneficiaries. But the lens and the discussions are through that of the provider, and the focus is only on payment levels. And I remain adamant that payment methods are at least as important as payment levels.

In interpreting 30(A), the federal appellate courts are split. Some look at the process the state used to ensure that provider costs were compared to provider revenue. What was the process that the state used to set these rates? And some look at the outcome. Are the outcomes sufficient to ensure access, quality, and efficiency?

Now, "quality" and "efficiency" are used in the decisions, and you can find those words, but they aren't discussed in any meaningful way, and they aren't given any granularity, nor would we want federal court judges -- it's hard enough for all of us who work in this world. So they're mentioned but they're not discussed. And

if there's one takeaway from the court decisions, it is that if the only rationale the state can put forward for its rate cut is we have a budget gap, no matter how courts look at it, the state's at risk. And so that -- and it's my last bullet here. I think that's the one clear takeaway.

So where does that leave us and where does it leave you? I think that the question is: What are the standards to apply to Medicaid payments to assure equal access, safeguard against unnecessary utilization, and to ensure that payments are consistent with efficiency, economy, and quality? Once we know the standards, then the question is: Well, what data should we collect against which to apply these standards?

Then, finally, I would pose a third question, which is: Where can CMS provide additional guidance, both in terms of giving meaning to these terms -- efficiency, quality, and access -- but also -- and that's why I put technical assistance. This really is complicated. I think I said this last time. There are better and worse standards or better and worse payment methods. And to the extent CMS is providing a national framework, I think all states would benefit. So I think that is the final question.

CHAIR ROWLAND: Thank you, Deborah.

Kathleen?

STATE PERSPECTIVE

MS. DUNN: Thank you very much. I really appreciate the invitation to be with you today.

So continuing with the theme of access, efficiency, and quality, it was those three things that really drove New Hampshire to take a step back and start evaluating its payment methodologies. And it was very easy to realize fairly quickly that we needed to start making some changes. So, with that, what I'd like to talk to you about today is how we went about reforming our hospital outpatient payment system.

Just to tell you a little bit about New Hampshire, we are really small. I feel fortunate that on any given day I'm usually only responsible for 120,000 covered lives. When I talk to my colleagues who have more like in the millions, I don't know how they do it. Our budget total for both acute care services, waiver services, everything, is about $1.2 billion, and I manage about half of that directly. About $580 million of it is in non-waiver acute services.

In state fiscal year 2010, what we saw was that our outpatient hospital services accounted for 53 percent of the payments to hospitals, so hospitals were pretty interested in what we were

doing.

You know our payment methodologies in New Hampshire, we don't have a one-size-fits-all, and over the years different people with really great ideas decided to come up with different ways to pay for different services. So for inpatient services, we use a kind of traditional DRG. We have fee schedules for professional services, and we also have -- which is where we had the problem -- cost-based reimbursement for outpatient services. And that truly did not help us at all. It was like working within a black hole. It was not transparent. It wasn't fair between hospitals. It was administratively burdensome and really did not incentivize providers to be efficient.

Thank you, Deborah. I forgot I had to push the button.

MS. BACHRACH: Yeah, I know. I always made a mess of it.

[Laughter.]

MS. DUNN: Thank you. So what we decided to do was -- I knew I wanted to do something about outpatient hospital payments, and luckily, we just happened to be on a regional National Association of Medicaid Directors call, and New York -- and I think it was Deborah -- spoke up and said something about converting an outpatient prospective payment system using a particular grouper, and I was

immediately enthralled and said, "Hmm, I wonder what happened here."

So we decided that, based upon our priority that we wanted to make sure that we chose the best solution, first for our beneficiaries and hospitals and taxpayers, our goal was to make this as transparent as possible. We wanted to reward efficiency, and we really wanted to be able to measure quality. That was an absolute had-to-happen.

So we were lucky enough to connect up with Kevin Quinn, whom some of you know as being a national expert in payment methodologies, and he came and talked with us about converting from this dark age outpatient cost-based reimbursement to something that at least got us into the 20th century, if not the 21st. And our choices were -- and we looked at each one of these in a great deal of detail, and I believe you all received a copy of our final report that we made our decisions from. We could retain the current system. That was a non-starter. We looked at the APCs or the Medicare-like ambulatory payment classifications. We looked at just doing a really quick hit and do a fee schedule. And then we looked at the enhanced ambulatory patient groups, or EAPGs, and we took claims, the same services -- we in partnership with Kevin Quinn and Kathleen Martin from ACS -- ran them through all those different methodologies. And

what ended up happening is we were trying to figure out how could we evaluate these options and decide what was the best methodology to choose based upon our criteria that we had set. And I wish I could say that I was the brilliant person that came up with this scorecard, but it wasn't. It was Kevin and Kathleen.

So what we did is first we brought all the hospitals in, and, of course, the first thing they said to us was, "Well, we want APCs." "Well, why do you want APCs?" "Well, because we know APCs." Well, that's nice, but APCs, I don't know if that's really going to get us what we need in terms of Medicaid.

So then we said, "Okay, what do you think about this scorecard approach?" And they were actually pretty interested in this, and so what we did is we assigned grades based upon the criteria that you see listed there. And I won't go through each one of them, but start with access and down to quality, and we evaluated our current method, the EAPGs, the APCs, and then the fee schedule.

What you'll see is that our current method had more F's than anything else, and, in fact, seven out of ten of the scores are D or below, and in my household that would get my children grounded for a month.

And so then we started looking at the other three

possibilities, and what we realized is that you have to make some trade-offs. And so first I was looking for a methodology where everything was an A and a B. That was going to be it. Then I realized that's just not possible. That's, you know, my coming up through school and nursing school. You had to have an A. That was it.

So as a group, we brought everyone together and said, okay, so where are we shining with A's and B's and where are we C or below? And so, you know, first I was concerned when I saw quality. Well, a C for an EAPG, but that's a whole heck of a lot better than a D and an F, which is what the other three options provided.

Then at first when we looked at administrative ease, we had just one category, and we said, oh, we better break that out because administrative ease for the state is different from administrative ease for the hospitals. And so we brought this forward, and, of course, they loved the cost-based reimbursement. You know, it took two to three years to settle a claim, but, you know, it was good. And they wanted to -- they said, you know, "Geez, Katie, we're going to have to go out and buy the software." And I said, "Well, gee, you know, you really don't unless you want to run your own claims data through and kind of see what's going to happen to your payments. But, no, you don't need to." But they've gotten over that, and, in fact,

once they saw the scorecard, they were completely on board. And I think it's really about having that conversation as early as possible and helping them to understand what this means.

So at the end of the day, we decided, okay, we're going to use the EAPGs, and then, of course, our next question was: So where are we going to get the data from in order to set the weights for these payments? And luckily, New York came to the rescue again. Because New Hampshire's population is so small or client caseload is so small, we couldn't evaluate it appropriately, and New York is so much greater that we said, "Could we borrow?" And, of course, they said yes, which is really very appreciative.

So the next thing we did is we looked at -- in terms of our evaluation framework, after we made the decision, we said, okay, are we meeting our goals? So the approach that we wanted, again, to take was we wanted to promote access to care, we wanted to reward efficiency. We wanted fairness. It didn't seem fair for one hospital to be paid one amount for the same service that another hospital was providing. We wanted transparency. We wanted every hospital and researcher, for those of you who like to do research, to be able to replicate our payment methodology and our quality results. And we wanted to make sure that we could, in fact, collect the level of

detailed data at a code level that we could really do some good work around quality of care. And so from our perspective, we believe we selected the payment that really does help drive that focus on high-quality care, and we're pretty happy with the decision.

The key issues that we came across, which I think a couple of these I've mentioned, there really wasn't a road map to guide us in this project. We have wonderful federal colleagues that we work with, but a call would -- you know, it's kind of like, So tell me what's available that would help me convert off this cost-based reimbursement system to something that's a prospective payment that makes sense and is based upon the federal guidelines? And it was kind of like, Well, here are some states you might want to call. And that's okay. But sometimes states don't have time to do that anymore because we've all had our staffs cut ridiculously.

Just to give you an example, a $580 million budget, my admin is 1 percent. I run the program on 50 people.

So we didn't have time to do a lot of that, so luckily, we've been trying to network through our association, and then we had -- because we didn't have that expertise anymore around data analysis and project management, we were lucky enough to be able to rely on a contractor, meaning Kevin and Kathleen, to help us through

this project and basically said tell us what you did in the other states, what worked, what didn't work, what lessons learned, and please tell me where the mine fields are because I don't want to blow up while I'm doing this.

Then the other thing that we found fascinating is that as we were beginning this payment reform on the outpatient side, we already had a number of state plan amendments sitting down at CMS, and we were getting feedback from all different corners saying, Tell us how you're calculating your upper payment limit.

Well, you know, after literally more than a year of going back and forth, back and forth, we finally said, okay, wait a minute, we have to redo our DSH, our disproportionate share hospital program. Let us figure out a UPL methodology, and we'll submit that and see how it flies.

But, again, it doesn't link the payment that we made, whether it's equal, greater, or lower than Medicare, to access and quality. It doesn't tell me anything to help me manage a program in a way that CMS and I think taxpayers and others would find to be reasonable.

So that's the story of New Hampshire, and I will tell you that I told Deborah today we are going to start a Payment Reform Geek

Club.

[Laughter.]

MS. DUNN: We're moving into inpatient reform next. We use MS or Medicare-based DRGs, and we're going to be moving to, again, an APR DRG, which is more Medicaid sensitive. So that's my next project.

Thank you very much.

CHAIR ROWLAND: Thank you, and now two new members of your Geek Club are right here to talk to us.

MACPAC ANALYTIC FRAMEWORK

MS. BARNETT: Thank you for the opportunity. We wanted to conclude this session with a brief presentation that ties together the remarks made by Katie and Deborah and to begin to lay out our initial MACPAC analytic approach on Medicaid payment policy, and Jim and I look forward to your questions and your feedback on our approach.

Today, we begin to dig a little deeper on Federal requirements for Medicaid payment and the State processes and approaches on Medicaid payment policy. We have learned the importance of getting payment right and have identified the need for frameworks to help States better link payment to access, efficiency, economy, and quality.

As we begin our analytic work in this area, we are mindful that, ultimately, the primary focus of payment reform and changes is the beneficiary. How do aligning payments improve beneficiary access to high-quality and efficient care? And underpinning payment for beneficiary care are broad Federal requirements that link payment with access, efficiency, economy, and quality. And as Deborah pointed out in her presentation, States have had flexibility to implement this provision and Federal guidance is largely focused on the upper payment limit and the public processes for changing payment.

With this flexibility, there's a lot of variation in States' approaches to implementing payment policy, as Katie Dunn outlined her State's approach to payment reform and how they evaluated payment methodologies across the different dimensions. But many States have noted that they lack the frameworks and the tools to implement changes to their payment systems.

This raises a broader question as to what the Federal and State roles are in implementing and defining payment policy. While New Hampshire and other States have taken steps to better link payment to access, efficiency, and quality, not all States have been able to move forward. Payment modifications are often driven by budget constraints and political pressures. And so we have outlined some

questions for your consideration, hoping to develop a framework.

What metrics and data are important for the Federal Government to collect and use in evaluating payment changes and providing oversight? What metrics and data are important for States to identify and collect to assess payment? And what are the implications for beneficiary access and quality?

With regard to processes, what are the Federal processes that are critical for assessing payment changes? What is included in the State plan amendment review process? What technical assistance is needed? And from the State perspective, what are the processes that are critical for States to follow in implementing changes to payment? How are beneficiaries involved in the process? And how are beneficiary access and quality assessed?

And lastly, to what extent is Federal guidance needed while balancing and maintaining the flexibility that is so important to the Federal-State partnership?

And just to serve as an example, our sister Commission, MedPAC, has developed a framework for determining payment adequacy and where access is a key dimension. As part of their evaluation, they use a number of metrics that look at access, financial performance, provider supply, service volume, and quality. We will

be considering other examples and metrics, but I just wanted to highlight this one as an example because it links payment with access.

And moving to our analytic approach, we recognize that this is just the beginning and we really look forward to your suggestions and feedback.

Overarching our approach is trying to examine what the Federal role should be in implementing defining payment policy, and Federal and State requirements offer a logical starting point, and Deborah has already started that discussion. So we are going to begin with the history of Medicare payment policy from the Federal and State perspective. And then, next, we hope to move to work with a few States to begin to identify some metrics and data that can be used to evaluate payments at a State and Federal level. We would like to examine how current payment systems came to be, reasons States succeeded or not in payment reform, and the tools and processes that States and the Federal Government can use to help assure prudent purchasing.

We will begin with physician payments and move towards institutional payments, and hopefully this will all lead to the development of a framework where we would like to consider the impact of beneficiary access and quality as well as States' ability to control and target their spending. We look forward to your feedback and

questions. Thank you.

CHAIR ROWLAND: Thank you.

COMMISSIONER COHEN: Well, I'll kick off. So I think in reading the materials and trying to process them and listening to presentations today, I know what I'm sort of struggling with is this connection between payment and access and how they relate. We all, I think, instinctively understand that they relate, but sort of more specifically how they do.

I want to throw out a very admittedly simplistic sort of statement, which I know is not perfectly right, and just sort of I'm interested in all of your comments on it. And one is that if you have access as one important goal, and efficiency and economy -- I'm going to lump them together -- as sort of another important goal, and payment is sort of the means in some ways to both of those ends, but payment, as we talked about, I think, last time, has these two components. There is level and there is methodology, and I'm sort of seeking some thoughts on it.

It seems as though level has a more direct impact on access and methodology maybe has a more direct impact on efficiency and economy, and I don't know if that's correct, but I just want to sort of throw that out as a topic for discussion and see if you have some

reactions. And Patti, it can be your reaction.

MS. DUNN: Here is my thought, and that is the way you outlined your concept is true, but I would also add that levels of -- you know, rates that providers are reimbursed at are only as good as the methodology that is used to set them. If you have a methodology that is not one that is transparent that you know what you are purchasing, you can end up wasting a lot of money, and if you are wasting money, that's money that's not going into and being invested in provider rates. So it's almost like the chicken and the egg type question.

I think that, although many providers talk about reimbursement rates and their concern about rates, in New Hampshire, our providers give us the feedback that they want to understand what they're billing for, what they're being paid for, how much they're being paid for it, but oh, by the way, we also would like you to pay attention to issues around patient compliance with showing up for appointments.

So, you know, we did a survey of our dental providers and said, tell us -- rank these three things and tell us which is one, two, and three. It was administrative ease of filing a claim, missed appointments, and rates. The missed appointments was the number one

problem that they had. So I think it might depend on the provider type, the type of service, but I think it's kind of hard to divorce them.

MS. BACHRACH: I would follow up on what Katie said. I think it's important -- we're talking about access to cost-effective, quality care. So I really do think the three goals go together -- access, quality, and efficiency. And I also agree, and you've all heard me say this, that you really can't divorce method from level. I mean, I understand the focus on how much physicians are paid in Medicaid relative to Medicare, but most of our expenses are not for physicians, quite frankly. It's for institutional providers.

And when we look at that, and it's interesting because New Hampshire and New York are following the exact same path -- we started by reforming our outpatient methodology and we chose APGs. We then moved to our inpatient, where we chose APR DRGs and New Hampshire is about to chose the same methodology. In doing so, we chose it because it will allow us to collect the data to judge what care our patients are getting in what setting and for what amount. And that's where it all comes together.

CHAIR ROWLAND: Steven?

COMMISSIONER WALDREN: Kathleen, I had a question about --

as we think about some of the things that we can recommend, and Patti talked about some of the issues around not having resources, and as a small State, you have been able to accomplish a lot. You've leveraged some of this stuff from New York. So I could see where, if you're talking about leveraging some of the data that you use to determine payment levels, that there were probably some issues there, differences between your population and New York's and your provider groups and hospitals versus them, but maybe could you talk a little bit about what were some of the challenges of leveraging their work to suit your needs and what did you have to work really hard on, and what were some of the things that were just like, that was a no-brainer. Like, was the scorecard very easy? There's nothing you really needed to do to adjust. You just need to apply your patient data, your State data to it.

MS. DUNN: Well, what we found was, first of all, hearing from New York that they had actually done this major payment reform, which I wasn't aware of, and, I mean, I tend to think of myself as trying to stay connected with the rest of the world, but sometimes you get kind of hunkered down in the weeds. So as soon as I heard that and my staff heard that, the next question was, how did they do it? And the only way I could get that answer was to actually call

New York and say, could you tell us who you worked with, because I knew, just like every other Medicaid Director, there's not a lot of time to sit down and teach somebody how they went about putting together a major payment reform project.

And luckily, because through a different connection I knew of a consultant that had done a similar transformation in other States, I was then able to say, look, we know this is what just happened in New York. Can you tell us how it happened and can you go through options with us? What I didn't have was a book that I could go to, like a Medicaid Directors Guide to Payment Reform, to say, here are some ways that you can make your outpatient hospital payments more effective, more efficient, based on quality. You can choose one of these three methods, and if you use one of these three methods and you submit your State Plan Amendment, you are going to be all set. I'm hoping CMS is going to approve our State Plan Amendment when they get around to reviewing it, and I have no doubt that they will.

And then in terms of the scorecard, truly, that was the brilliant idea of Kevin Quinn and Kathleen Martin. First, we thought, do we try to look at it from a dollar sign perspective, you know, where were you seeing the best, like, fiscal impact bottom line, and that just wasn't flying because our priority was the beneficiaries,

what was the outcome for them.

And then our next priority was, so, when I'm asked a question by a New Hampshire legislator or a taxpayer of why did you pay for this service and how did you pay for it, I wanted to be able to answer that question.

But now that we have that framework, I will never probably go away from it because it has been so effective and using a balance of really a quality assessment to making the decision as opposed to just relying on what was the bottom line financially.

Did I get all of your questions?

COMMISSIONER WALDREN: Yes.

MS. DUNN: Okay.

COMMISSIONER WALDREN: [Off microphone.] Having that card, the pamphlet --

MS. DUNN: Right.

COMMISSIONER WALDREN: Sorry. Yes, you did, because I think the issue was what are the things that could be leveraged across multiple States was kind of my underlying question, and you talked about that and a guide book --

MS. DUNN: Right.

COMMISSIONER WALDREN: -- so you've answered the question.

MS. DUNN: Definitely.

CHAIR ROWLAND: Definitely a guide book. Sara?

COMMISSIONER ROSENBAUM: That was a great panel, and I have a question. I think it actually is a follow-on from Deborah's comment, but I was actually thinking about it in the opposite order. So we have this task of trying to figure out really what (a)(30) means from this conceptual point of view, and it occurs to me as I'm listening to the panel that our biggest struggle is actually less the access part, I mean, this is a huge piece of work to figure out what we mean in access, but this relationship between efficient and economic and access.

And so the question, I guess, is whether we should be thinking about efficiency and economy in relation to what, to inappropriate access. So, for example, if you have a poorly functioning health care system in which every Medicaid beneficiary is substituting either delayed care, no care, or care in very inappropriate settings for care -- they're going to hospital emergency departments instead of to a physician's office, if they are putting off certain kinds of care, if we're seeing people at very critical disease stages -- should we be trying to draw the link for Congress between those kinds of access outcomes and efficiency and economy?

I guess my curiosity is, do you understand efficiency and economy to be in relation to, let's say, the unit cost of a service, or in relation to the broader functioning of a State Medicaid program? And Kathleen, I'm particularly interested in sort of the -- the scorecard is great, but I'm wondering, when you went into this, what was your underlying driving thought about how to think about hospital care.

MS. DUNN: Well, being a nurse and a critical care nurse by training, the first thing that I realized when I started looking at our data was that we were paying for services that that money could have been used for other things. So let me give you a very concrete example.

A patient came in for a laryngoscopy. They were going to put a camera down and look at their larynx. They have set up the operating room. The anesthesiologist is there. The patient is asleep, you know, the IV is started, the whole nine yards. And the surgeon does the laryngoscopy and he gets in there and he goes, "Oh, I need to do a biopsy." In the old system, payment system, we got billed for two OR set-ups, two different procedures, two different anesthesia bills, two different sets of supplies, when in fact what happened was it was one procedure, and after looking down there with

the camera, the surgeon then put a little forceps in there and took out a bite of tissue.

And so when we started looking at that, we thought, man, if we're doing that with that one little procedure, what are we doing in other places and is there a way that we could capture some of those savings and reinvest them into perhaps provider rates, maybe better care coordination. Could we support our primary care doctors through loan repayments better so that we could help our workforce issues? So that is how I got going on it.

COMMISSIONER ROSENBAUM: So the rates for hospital care were viewed in relation to broader efficiency measures throughout the Medicaid program.

MS. DUNN: Correct.

MS. BACHRACH: If I could just follow up with a similar example, when we were paying on a per visit basis, we paid hospitals the same amount for every visit, $67.50, and we only permitted one visit per day, and so it was in their interest to churn as many visits and have the person come back as many times as possible. When we moved to APGs, we can bundle and package in a way that we recognize the second visit, but we discount it because some of the prep has been done relative to the first visit. So either way we assure access,

but the second way assures it in a more efficient way, efficient in dollar terms and for the patient, as well.

CHAIR ROWLAND: Donna?

COMMISSIONER CHECKETT: Yes. I have a couple of questions for either Katie or Deborah. When you did your payment reform, did you reinvest all of your dollars or did you cut? That would be the first question.

And then the second question is, did either of you run into problems with having payment systems that were really justifying DSH or UPL, and when you reformatted, how did you deal with those?

MS. DUNN: Have fun.

[Laughter.]

MS. BACHRACH: Right. Well, we were lucky in that we started before 2008. So we started in 2007 and we did inpatient and outpatient analytics together. So we learned first that we were overpaying for inpatient care and underpaying for outpatient and we were able to move most of our money from inpatient to outpatient. So we had to give some of it back to the State treasury, but we did take $600 million and move it from inpatient to outpatient.

With respect to DSH and UPL, two different issues. On UPL, we had, you know, the UPL payments, we had add-ons for everything,

you know, from the door had to be widened, to years ago there was an add-on for hazardous waste cost, to one group of hospitals came in and argued and the legislature gave them add-ons. So we had add-ons, also known as UPL payments, because they always have to be below the UPL.

So what we were able to do, and this was incredibly controversial, was we were able to take all of our add-ons, some good, some bad, all irrational, and we put them into our base rate. So it was an enormous political fight and it's one of the things I'm proudest of. We actually did that. So we moved it into the APR DRGs, our inpatient system with a base rate, where the only differentials are for teaching and patient acuity and labor costs.

But that is a big, big issue, and it goes to Katie's point about by doing that, we now have transparency so we know what we're buying. Had we not been able to, or if they slip and start back with the UPL add-ons, we will lose all the advantage of all that work we did.

COMMISSIONER CHECKETT: I would congratulate you on your real reform.

CHAIR ROWLAND: [Off microphone.] Katie, did you want to comment?

MS. DUNN: Sure. In terms of the question about did we reinvest all of our money, three primary things happened by looking on the outpatient side. One was we didn't have to go back in and reduce outpatient and inpatient hospital rates again, which had already happened in 2008 and 2009, so that was important. We were able to maintain Critical Access Hospital reimbursement at an enhanced level, whereas the other hospitals, acute care hospitals, had seen pretty significant reductions. I thought that was kind of important. We were able to maintain our dental rates. Every other provider had undergone a rate reduction, but we were able to hold our rates, which was important. And last, we were able to pop up our home health rates. It was just a little bit. It was only 2.7 percent. But it was important because it helped keep people out of the hospital in the first place. So that's what we did there.

And in terms of DSH, if you wanted to go for your Ph.D. and write about New Hampshire's DSH program, I would be happy to help you with it. We are --

[Laughter.]

MS. DUNN: Let's just say we're a little bit outside of the norm, so there wasn't any big deal that happened from this particular reason.

MS. BACHRACH: I would just add on DSH, you should put New York in that dissertation. DSH is a black box, a black hole. I mean, it is, and to the extent this statute says DSH payments cannot -- can be the delta between what Medicaid pays and the providers' costs, it tends to undermine the efficiencies you achieve in a sound reimbursement system.

CHAIR ROWLAND: Excellent. Now we are going to turn to Patty.

COMMISSIONER GABOW: I have three questions and one comment. The first question, someone could explain to me, there was the Federal amendment that required actuarial soundness, right, and that was done away with. So could someone explain whether -- what that amendment's purpose was? I mean, I think I know, but -- and when it was done away with, is that what has led to so many lawsuits from the State, because there was benchmarks? How does that link -- I'm confused about that. That's my first question.

CHAIR ROWLAND: Do you want us to take that question?

COMMISSIONER GABOW: Yes, maybe. Maybe I'm so confused, you can't answer the question.

COMMISSIONER ROSENBAUM: The link between the (a)(30) litigation and the earlier Boren litigation. Maybe that is the issue.

The issue is, I think, the link between the efficiency litigation and the rate-setting litigation and the earlier Boren litigation back from the early 1990s.

MS. BACHRACH: Sara, you are probably better equipped to talk about Boren. I managed to skip right over it and go to current.

COMMISSIONER ROSENBAUM: I mean, I would just note that at one time, the Medicaid statute actually put a payment standard into the law and there was a frame of reference for judging payment, whether people -- and the irony is, the payment standard was what an efficient facility would get paid. There was much litigation to enforce that standard and typically it's very similar to what Deborah has found around (a)(30), which is that the litigation would tend to say, whatever it means, the State didn't do it. So it was less about what the actual standard was or even the methodology for getting to the standard than the fact that the State wasn't going through a process.

CHAIR ROWLAND: But it also applied to nursing homes, to hospitals --

COMMISSIONER ROSENBAUM: Yes, absolutely.

CHAIR ROWLAND: -- to hospitals, not to physicians --

COMMISSIONER ROSENBAUM: Right.

CHAIR ROWLAND: And it was one of the key issues the States

requested for additional flexibility. The repeal of the Boren Amendment, because of those lawsuits, became a huge issue for the States. They wanted out of the Boren Amendment and that's what they got. And so some of the new lawsuits that are being talked about would be, in fact, because that standard is no longer there.

COMMISSIONER GABOW: Right. So it seems like even though there were lawsuits related to the standard, removing the standard has created --

CHAIR ROWLAND: Created additional --

COMMISSIONER GABOW: -- another set of lawsuits.

COMMISSIONER ROSENBAUM: And very similar lawsuits.

COMMISSIONER GABOW: So that was my question.

My other question about the lawsuits is there are certainly a lot of groups who feel that Medicare payment is not adequate, but we don't seem to see lawsuits about that compared with the lawsuits about Medicaid payment being inadequate. So in trying to decide what a solution is, does anybody have an idea of why the Medicaid inadequacy of payment is going through the courts and Medicare inadequacy of payment is going somewhere else?

COMMISSIONER ROSENBAUM: I actually think that's an artifice of the fact that you can't challenge directly -- under

Medicare, you can't challenge the payment. What you can challenge and what is just spilling over in Medicare is, of course, individual cases in which a provider believes that under the prevailing methodology and standards and the particular rate structure that the provider is paid at, or the supplier, that it somehow got gypped. So there are tons and tons of appeals. But what you can't do is the kind of head-on challenge in Medicare that all hospitals can do in Medicaid or all nursing homes can do.

CHAIR ROWLAND: Well, and also, many of the changes in Medicare payment policy are statutory changes as opposed to --

COMMISSIONER ROSENBAUM: Right. You just can't take it on --

CHAIR ROWLAND: -- just across-the-board cuts or whatever, or they are statutory across-the-board cuts.

COMMISSIONER ROSENBAUM: Right.

COMMISSIONER MOORE: And you have got a PRRB, a Provider Reimbursement Reward. That's another level.

CHAIR ROWLAND: [Off microphone.] Do you have more --

COMMISSIONER GABOW: Yes, two more. Sorry. It would be useful if you could share with us the granularity of what was in the scorecard. What's under the rubric of quality and administrative

efficiency, because I couldn't find that and that's obviously key.

And my last is just a comment. I was impressed when you said, Kathleen, that you have 50 people managing a $580 million program, and this may be something that the Commission wants to think about, is what is the adequacy at the States for managing such a complex insurance program? And to Rodney's question this morning, if this were United Health Care, how many people would be managing this, or whatever. But I think that it's just interesting, and in this same token, I mean, if you compared that to a commercial program, it's not just the number of people managing it but the salary level of the people who are managing it. And I think for everybody who wants to put this into the private sector, put everything into the private sector, some comparison that's pretty granular about the efficiency would be -- I think has some utility.

COMMISSIONER RILEY: I hate to follow that. I had two questions. One was: When you look at 30(A), it starts with -- the first criteria is to safeguard against inappropriate -- unnecessary utilization, and it strikes me that's what I don't like about the MedPAC definition. That's very much absent in that definition. I think it's critical about the issue of we provide too much care frequently at too great a cost.

You talked a little bit about the churning on the volume side. Can you talk a little bit more about how these reforms have addressed inappropriate utilization? And, secondly, could you talk a little bit about -- CMS has clearly taken this on. We clearly know that from the challenge in the courts we need to have some help. On the other hand, if CMS comes out with proscriptive regulations in the financial environment we find ourselves in, states can't -- maintenance of effort, you can't deal with eligibility, you can't -- I mean, where does that leave you if CMS comes out that proscriptively? So two question: overutilization and how to approach the CMS issue.

MS. DUNN: Okay. On the utilization piece, a good example of what we've seen is that hospitals have recognized that they have -- it is less expensive to have somebody who's having some of the procedures that were being done in a day surgery center, particularly where there's all the hospital overhead, et cetera, that those same services could have actually been provided within a physician's office. There isn't all the extra overhead there. So that has shifted the focus, and it has also helped -- instead of having people coming back two or three times, there's a whole lot more care coordination going on and people trying to work together, different

provider types, to say, well, if Mr. Jones is coming back after his procedure he had in the doctor's office, but he also is a diabetic and he needs to talk to a nutritionist, let's just do it all at once. And so, you know --

COMMISSIONER RILEY: [Off microphone.]

MS. DUNN: That's what we're starting to see, and actually to your question, Trish, I think that what you'll see is New Hampshire will do a follow-up report and publish what happened, what we learned, and what has happened since then. And, I'm sorry, I've already forgotten the other question.

MS. BACHRACH: Let me answer utilization while you think about [off microphone].

I think on utilization a good example is we're trying to bring down emergency room utilization, and so when we went from per visits -- because we were paying ED visits per visit and clinics per visit. When we went to an intensity-based, we dropped our ED payments for care that could be provided in a clinic down to, in some cases, less than we will pay in the clinic. So we are creating the incentive to move people into the clinic and out of the ED, and we couldn't do that when we paid per visit. We could only do that when we moved to a methodology that was intensity-based.

And the other point I would make on utilization is it's not only the amount we pay but relative to each other, so that when we moved up our ambulatory surgery payments and moved down some of the inpatient payments, we moved out of hospitals and into am surg. And in both of those cases, it was a combination of method and level that did it.

COMMISSIONER RILEY: But a good example of why you can't look at payment by single issue.

MS. BACHRACH: Absolutely. Level is relative level, and it goes with methodology, because that allows you to nuance the level. And I'll start on the regulation and flip it back.

COMMISSIONER COHEN: Can I interrupt for a moment?

MS. BACHRACH: Sure.

COMMISSIONER COHEN: Have you had enough experience to see results on the emergency room outpatient?

MS. BACHRACH: What I would say -- and then I'd want to go back to my former colleagues -- is they reported and they have documented increased documentation of what's happening in the visits, or our data has improved. So whether there's enough experience yet to demonstrate that, there's definitely enough experience to tell you we're getting the data that will ultimately allow us to document

change or not.

COMMISSIONER ROSENBAUM: And, I'm sorry, can I jump in with just a follow-up before you move on to the next issue? I hear you saying that by moving to an intensity-based system, you actually are able to generate some substitution that otherwise might not -- I mean, this whole thing is predicated on the notion that you can get substitution. If what you want to do is substitute a doctor's office for an outpatient clinic, you have to have a doctor's office you can substitute into, and the big conundrum in Medicaid is there are very few participating doctors. But if you move to an intensity-based system where payment is much more aligned with the characteristics of the patient, the resources needed, the scope of what's payable, that you may then begin to generate substitution that is, in fact, more aligned with both access and deficiency.

MS. BACHRACH: Yes, and I totally agree with that, and to facilitate that, we paid more -- at the same time we were doing these reforms, we increased payment for doctors in underserved areas, and we increased payment for doctors that stayed open nights and weekends, as we did for clinics, because I just think it's important -- like it or not, a lot of Medicaid patients are getting access through hospital clinics and community clinics and FQHCs as well as physician

offices. So we should be looking at the panoply.

CHAIR ROWLAND: Deborah, in addition to that, did you do anything with scope of practice to broaden the availability of who people could see, not just payment?

MS. BACHRACH: We didn't, but I have been talking to our education department, and they're going to take a hard look at all of our scope-of-practice laws in New York to make sure that they are permitting mid-level practitioners to practice to the top of their license. It hasn't been done, but it is on the radar screen.

CHAIR ROWLAND: And, Kathleen, I think that Patty had a question about the quality measure on your scorecard that we -- the variables that we didn't get answered, so let me go back to you.

MS. DUNN: I'm glad you went back to that because I wanted to let you know that within the document, the New Hampshire report, and also there's an article by Kevin Quinn -- but I'm hoping you received a copy of that report. Each one of those criteria is spelled out in detail with a description, so, you know, whether you're looking at --

CHAIR ROWLAND: We didn't get the whole report, Patty, so it wasn't that you missed it. But I can be sent to you. I'll send it to you.

MS. DUNN: Oh, I'm sorry. I would have brought some with me if I had known that. But, you know, it is there. Each one of them -- access, efficiency, fairness -- each one is spelled out with a description, and it talks about what the factors were that went into consideration. And after you've had a chance to look at that, I'd be happy to follow up with any questions that you might have. I think that -- and, actually, I would be interested to hear what your thoughts are and how we described them.

CHAIR ROWLAND: So we'll get that material sent out to all of the Commission members.

Deborah, did you have a comment?

MS. BACHRACH: Well, I wondered if we ought to come back to Trish's second question, which is: Do we want proscriptive regulation out of CMS? And I think if we want -- I would like to see regulation out of CMS. I think that there is an appropriate role of state flexibility. It is a federal-state partnership, and the federal government is certainly sensitive to the budget constraints of the state.

On the other hand, if you just look at the New York-New Hampshire example, you couldn't find two more different states. We both spent money on consultants. We both spent hundreds of hours of

staff time and an equal amount explaining the APG methodology to CMS. We both had to go to our hospitals and our legislature and explain why we weren't using APCs, the Medicare approach. And we had MedPAC support for what's flawed about APCs and why APGs were better.

Think about how much time we spent reinventing that wheel. Two different states reached the same conclusion. We had lunch together and laughed. We had the same hurdles to overcome. We made the same arguments. And we had to educate CMS staff, who was not familiar with any payment methodology, much less APGs.

If CMS put out guidance that said we have to address the standards in 30(A), but how about just saying APGs are a preferred methodology. They're not required, but here they are. Here are states that have adopted them, and if your SPA, your state plan amendment, shows that you are using APGs and weights that we've already approved, you'll fly through, because we will both tell you that SPAs can take years to get through, and that's just not workable.

And I also think when we move from per visit or cost-based to an APG system, you will save money without taking dollars out of the system, much as Medicare did when it moved to DRGs in the 1980s, and states desperately need that. So I think there's a balance between being too proscriptive and being enormously helpful.

And then, finally, it's the lawsuits. I mean, all state Medicaid directors are worried about these lawsuits, and with some federal guidance, that's a defense in court. So I think there's a balance, but we're ready to move.

Then my one last point, think about how states really, really asked for federal guidance on eligibility systems. And in the last two months, the Federal Government, you know, after much -- and, Trish, you know this. States were desperate. Why are we all figuring out this highly complicated area of electronic eligibility systems? I think states are at the same place with respect to payment systems. And we both attended a meeting in Baltimore several weeks ago where I think we heard that loud and clear from our state colleagues.

MS. DUNN: I think building on what Deborah said, you know, it isn't a one-size-fits-all situation in terms of looking at one Medicaid program to the next Medicaid program, because it is that federal-state partnership, each state having its own health policy priorities, et cetera.

But I do think that there are best practices. There's best practices in transforming from, you know, a cost-based reimbursement system to whatever it is that your state chooses. And if those best practices can be identified and if we know that in order to achieve

approval and, therefore, receive the federal match, plus be ready to answer all of CMS' new requirements regarding quality, that if you do these things, if you follow this road map and here is a state plan template, it will go faster, and you will reap the benefits on both the federal and the state side, and then ultimately in the middle that we're both trying to hold is the beneficiary.

So, you know, again, I think it's a matter of, you know, consistency between the regions. I think it's a matter of helping states identify best practices, helping states not have to reinvent the wheel. You know, that type of thing would really be helpful. I might not have needed CMS to say, New Hampshire, you will do EAPGs, but to be able to have them say, you know, if you use this methodology, here are some of the specifics behind it, you know, pros and cons type thing, it would have saved a lot of time and research particularly.

CHAIR ROWLAND: Andy?

COMMISSIONER COHEN: Back to a question that I sort of asked before, you know, at least certainly to me, the theory makes a great deal of sense about incentivizing the right things, but I'm just wondering how much evaluation there has been yet. And that doesn't go to, you know, nobody should move until we know everything that

happened. I don't mean to suggest that at all. But I think we also should just be aware that there -- I think health care has a little bit of, like, you know, everyone's looking for a solution and there can be fads, and I think we have to be really, you know, cautious to recognize what we do know, what we don't know, and what is something where somebody comes up with a new product or approach every few years and not, you know, try to shoot everyone through long changes.

What's the literature evidence out there or what do we need, what's a fair amount for CMS to need really to say that one particular approach is sort of approved for everyone or preferred or recommended?

COMMISSIONER RILEY: Just to the same question, the unintended consequences, because every time we change how we do rates, something else -- some other end of the bubble bubbles, and I wonder if you've thought that through in your evaluation.

MS. DUNN: I think the right place to start, regardless of whether you're a federal agency or a state agency, is what your guiding principles are, what are the values, what is it that you believe is most important to hold in front of you. And if your guiding principle is transparency, if it's being fair and paying providers who are providing the same service fairly and in an equitable way, an ability to monitor quality, assuring that you're doing the best job you can

to be efficient in terms of a patient's time that is being spent within a particular provider venue, that's what helps to drive what ends up on the table as a possible best practice that a state may want to choose.

You know, there is some literature out there about, you know, just the fact that a state recognizes that they've been paying for -- through cost-based reimbursement. You know, I had no idea that New Hampshire was paying for lab work as part of an outpatient surgery that had been done within the previous 60 days that could have been very well used again.

So just knowing now that when I get a claim, the CPT codes, everything is listed there. I can drill it right down and tell you exactly what tests they had done, and that has been really important. I don't know if that quite got to where you wanted to go, but let me ask Deborah.

MS. BACHRACH: I have more trouble giving a principle, but I can give an example. Let's go with DRGs. Medicare went to DRGs in the 1980s. They have been proven successful. We have somewhere between 10 and 12 states that are still paying either cost-based or per diem, and that should be a problem.

Now, there may be a reason to do it, and there may be an

answer, but if we're not by 2010 saying why are you still paying on cost-based or per diem when Medicare DRGs are uniformly acknowledged as a successful payment reform --

COMMISSIONER COHEN: But I know you don't think that you should have to wait 20 years to --

MS. BACHRACH: Right, right. But I think we both conclude APGs are a sound payment methodology, and they are, in fact, better for Medicaid than Medicare. I don't think -- and we've both said -- that CMS should say to states you have to do this, but CMS has an awful lot of ways to both inform and incent states to do a payment methodology. The two states, two very different states, using and paying different consultants reached the same conclusion.

CHAIR ROWLAND: Judy. Donna.

COMMISSIONER CHECKETT: Well, I was just actually really intrigued by this point, and so I just want to make the observation for the Commission that in our deliberations it is worthwhile us thinking how can CMS be a helper, not a hindrance, which is, I think, how they're often sometimes unfairly perceived. And it would be a beautiful day if they started asking why are you paying fee-for-service. And should the Medicaid expansions and the ACA go through and be effective in 2014, they actually, much more than the

states, will have a vested interest in this new population. Those people are free to the states. States honestly -- you know, managed care, why bother? You know, just let those claims go through. And, really, it is interesting to think about the fact that now CMS needs to be thinking about how are we paying for these people, are they getting appropriate care, et cetera. So just an observation.

CHAIR ROWLAND: Okay. Sharon.

COMMISSIONER CARTE: It sounds like you're really saying that CMS needs its own scorecard of payment methodologies that it holds out in front of states that would promote efficiency and economy. Right?

MS. BACHRACH: Yes, and work with states in developing it so we're on the same wavelength when we come in. So their expertise is sort of on both sides of the aisle, so to speak.

CHAIR ROWLAND: I think it would be helpful for the staff, for Patti and Jim and the team, to hear any additional comments that the Commissioners want to make about shaping this work, and the panel has given us some great insights into what we should be looking at. But are there any additional suggestions. Patty?

COMMISSIONER GABOW: I just want to clarify something. When you say you've gone away from cost-based reimbursement, does

that mean that for your FQHCs in your state you're not longer doing cost-based reimbursement?

[Laughter.]

MS. DUNN: You know, I am so happy you asked that question. No, because under federal law cost-based reimbursement, particularly under BIPA 2000, it's a prescribed payment methodology. And understanding that I was one of the people that helped established the primary care centers in New Hampshire and that I love every single one of those executive directors, I'm not sure cost-based reimbursement is the best methodology. I'm not sure it's serving them well. When we do a comparison of our outcomes of certain HEDIS measures and utilization measures, comparing our commercially insured versus a particular large provider network versus the FQHCs, I expect to see a statistically significant difference in the health centers, and it's not there. And I think the only way to be fair to the health centers and to be fair to the taxpayers who are investing a lot of money into that system is to drill down and figure out what is going on underneath that cost-based reimbursement.

MS. BACHRACH: My pet peeve is that when we went to APGs for all of our hospital clinics and all of our clinics, the FQHCs refused to go into the new system because it was more complicated.

And I, too, love the FQHCs, but that means I don't have the data to demonstrate that the added costs that we're paying are producing better results, and that's tremendously problematic.

CHAIR ROWLAND: Additional guidance for the staff?

[No response.]

CHAIR ROWLAND: Well, on that note, I would like to thank our panel for a rich discussion that has really helped to inform our discussion, and we will be continuing to weave this clearly through. It's access, it's quality, it's not just payment. But I thank you for advancing us one more step on the path toward better payment, better access. Thank you.

Now I'm going to ask April to -- we're going to postpone our break a bit and ask April to come up and kick us off with the discussion about how we have data to understand any of this.

CHAIR ROWLAND: As you might recall, at our earlier meetings, we had representatives from CMS come talk to us about some of the challenges with program data and administrative data, and what some of the plans were at CMS for trying to improve and revise the way in which they collect and utilize much of the information we have on the Medicaid program.

As we've talked about so many times, there's both

administrative data and survey data. Tomorrow we'll be looking at how survey data can help answer some of the questions that we want to see answered in our deliberations about the Medicaid and CHIP programs. But April is going to focus today on some of the areas where we might make some recommendations around program administrative data. Thank you, April.

IMPROVING ADMINISTRATIVE DATA FOR PROGRAM ACCOUNTABILITY AND POLICY ANALYSIS

MACPAC WORK PLAN AND OUTLINE OF OPTIONS

MS. GRADY: Thank you, Diane. I feel a little lonely up here after the last full panel, but that's okay.

As you know, one motivation for our work on this issue is that MACPAC has a statutory requirement to review national and state-specific Medicaid and CHIP data and to submit reports and recommendations based on those reviews.

Today I'm going to build on, as Diane said, previous discussions by describing some of the important federal administrative data sources that were not covered in our October meeting, but I'm going to spend most of my time laying out some options for you to consider as you think about potential recommendations from MACPAC's March report to Congress, and we, as always, look forward

to your comments and suggestions on these issues.

As Diane mentioned, you heard presentations by Penny Thompson about data initiatives underway at CMS and some of the challenges they're facing. One source of challenge, as we all know, is the complexity of the programs and the high degree of variation across states. It makes it very difficult to collect standardized information that we can compare on an apples-to-apples basis.

You also heard about some of the data sources that serve as the basis for many analyses of enrollment expenditures and service use, and we talked a little bit about how those data are useful for research and some of the areas for potential improvement. So I'm not going to go into detail on those because we have spent time on them previously.

The next two slides I'm going to show do mention some additional federal administrative data sources that are important for Medicaid and CHIP, but I'm not going to go into detail on each one of them because they were covered in the background paper that you received. However, on this slide, I do want to spend a little bit of time on the CMS -416 data because it's one that you'll hear about again, I think, in a number of contexts, perhaps in the dental session today.

Under Medicaid's Early and Periodic Screening Diagnostic and Treatment requirements, or EPSDT B I know that's one of those acronyms, but you'll learn to love it -- for children, states must cover certain periodic screening, vision, dental, and hearing services as well as any medically necessary service that's listed in the Medicaid statute, and that's regardless of whether the state covers that service otherwise. If it's listed in the statute and it's for a child, the state has to provide it.

The form CMS-416 is what CMS uses to track the extent to which some of these EPSDT services are being provided to children. However, the information collected is very basic. For example, it looks at the percentage of children in a particular age group who received at least one well-child visit or at least one dental preventive or dental treatment service.

Again, I don't want to go into detail on each of the items on this slide, but here I just wanted to lay out some of the administrative data that are specific to state program characteristics, and the main point here is that there are a number of ways in which CMS collects information on Medicaid and CHIP program characteristics.

These include things like eligibility levels, covered

benefits, and provider payment methods, and that may be under the regular - what we call state plan - rules that are detailed in the statute, and they may be under waivers that allow states to operate their programs outside of the normal state plan rules.

Here I want to talk just briefly about some of the gaps in data sources that I've mentioned today and emphasize that it's important to discuss these gaps, as we have in the past, because they matter for policy analysis and they matter for program management.

For example, we rely on the CMS-416 data to tell us about service use among children and whether they're receiving the care that's required under federal law. However, there are concerns about the comparability of this data across states. We don't have great information about how states calculate some of the measures that are on the 416, and although the data do cover both fee-for-service and managed care enrollees, there's no break out of fee-for-service and managed care separately on those forms.

GAO has noted some concerns about the data being limited in their usefulness for oversight and the level of detail they provide on utilization for dental services in particular, something you'll hear more about later.

CMS is considering changes to this Form 416, but a

fundamental issue is that it only collects a pre-defined set of aggregate statistics. In contrast, the claims level data that we've talked about in our previous meeting allows the flexibility to drill down farther into potential problem areas without having to add or change state reporting requirements on this form. The way I think about this is, is sort of ordering off the menu versus building your own sandwich. So the 416 is the menu, but the claims data lets us have our sandwich.

Another area of concern is that the current sources of information on state programs, including state plans and waiver documents, are in formats that make it very difficult to summarize or link that information with other data sources. CMS recently compiled data on eligibility and benefits for HealthCare.gov. That's something they mentioned when they were here earlier.

But that effort required a sizeable team of people to review documents and pull that information out manually. They're now considering how to handle updates to that information and put additional information into a more usable format, but that process is still under development.

One example in the recent state Medicaid director letter that was issued on the new health home provision for enrollees with

chronic conditions, CMS mentioned that it's going to be allowing online submissions of those state plan amendments. And that could make things somewhat easier.

One concern I just want to mention quickly that we've heard from states about this electronic format of state program data and, Andy, this relates to one of the questions you had for us last time about potential pitfalls of making things more accessible.

One of the concerns we've heard is that states are worried that just by putting this data into a new format, it's going to cause CMS to reopen what they view as settled issues in their state plan amendments, so that increased scrutiny is something that they've voiced as a concern.

Before we're going to talk about options for improving the federal administrative data, which is the focus of this presentation, I just want to briefly mention all payer claims databases because this keeps coming up as something of interest.

Generally these databases contain information on services provided by private plans and by Medicaid and some states are just beginning to obtain Medicare data as well. They're useful for states because they can provide Medicaid and CHIP with benchmarks to compare against. For example, looking at private plan payments or private

plan utilization, enrollee utilization of emergency departments and other services.

The NGA and others have been discussing standards for providing consistency in these databases across states, and MACPAC is also wanting to get some experience in using these databases, so we're working with Maine to take a look at primary care services in their database across the Medicaid and private information that they have.

Chris Peterson, one of our MACPAC staff, recently attended a conference on these all-payer claims databases and met with folks from Utah who are working on these issues.

Now that you have more background that you probably ever wanted on federal administrative data, I'd like to talk about how we might move forward on this issue. Based on comments and guidance from the Commissioners are our previous meetings, we've developed some options for you to consider today as you think about potential recommendations for MACPAC's March report to Congress.

We recognize that you may have additional thoughts and suggestions and we certainly welcome those and look forward to your feedback. After today, we plan to consult with states, CMS, and others about any options that are under consideration, and we'll also be

looking at some case studies that demonstrate the value of these data sources that we've been discussing.

I'm going to go through each of these individually, but for reference, this is a list of the options I'll present today. Again, we're looking for your feedback on these and suggestions for additional options.

The first option the Commissioners might want to consider is encouraging CMS to expeditiously issue regulations on managed care encounter data that are currently under development. This is an issue that a number of you have expressed interest in in previous meetings, and the timely issuance of these regulations would help to speed the process of obtaining encounter data from all states. As you know, only some are currently submitting this information to the Federal Government.

The HHS Office of Inspector General has found that some states report difficulty in using these data and would welcome more guidance and information from CMS, but it's also important to point out that again, all states are currently collecting this information and it's a matter, in some cases, of starting to report it to the Federal Government.

In addition, some states have been using encounter data

for more than a decade and have told us that CMS -- they really hope that CMS would take their experiences into account in the development of these regulations. So it's something to keep in mind.

As we've talked about before, improved encounter data collection could allow for a range of analyses that we can't currently do, and that includes getting a national picture of variation in managed care access, utilization and quality, both now and in the future, when the program is expected to grow significantly as Medicaid eligibility is expanded. It would also allow comparisons of care received by managed care and fee-for-service enrollees.

For example, we could look at rates of preventive service use among these populations, we could look at hospital admissions and re-admissions, and potentially preventable emergency department visits. And all of this is possible at the state level right now. We just can't do good national and cross-state comparisons because of the lack of information.

One other thing that might be possible if we had encounter data would be to directly calculate some of those EPSDT measures on the CMS-416, and calculate a wider range of measures and look into areas that are not currently explored on that form.

Another possibility would be to use the data to calculate

some of the voluntary child health quality measures that were developed under the Children's Health Insurance Program Re-Authorization Act. Right now states can submit those measures voluntarily, but if we had data, we could calculate them for the states. CMS could calculate them and lift some of the burden of that reporting.

The second option the Commissioners might want to consider is encouraging CMS to require state reporting of data on separate CHIP enrollees in MSIS, and if necessary, encourage Congress to grant authority to CMS to do so. There's some question about whether the statute allows CMS to request this detailed information from states, but that's something to consider.

This would include person level data on enrollee characteristics like age, race, eligibility criteria. It would also include claims level data on service use and expenditures, and this would allow for the same range of analyses that I described for option one, plus it would allow for comparison of Medicaid expansion and separate CHIP enrollees whose coverage can differ in significant ways. So that's something we can't currently look at because we don't have good information on the services that the separate CHIP enrollees are receiving.

The other issue I want to point out is, if the Medicaid Statistical Information System, the MSIS, was used as a model, it would eliminate the need for a new data source. States are already set up to report this information for Medicaid and this would be an expansion to separate CHIP programs.

The third option the Commissioners might want to consider is encouraging CMS to consolidate federal administrative data sources with overlapping content to the maximum extent possible. There's been discussion amongst the Commissioners in previous meetings that there's too many requirements on states, a lot of different sources. Penny Thompson had a slide at our last meeting that showed all kinds of acronyms going into a bucket at CMS, and they recognize that there's a lot of information being requested of states.

The consolidation of these sources would serve two purposes. It would reduce the state reporting burden and it would lead the remaining data sources to be used more frequently and more widely, and that's likely to generate improvements in the data over time. If we're using it, it's going to be exposed to more scrutiny and we'll have better information.

Identification of the gaps and inconsistencies between existing data sources would be important first steps for

consolidation. For example, the options that I've mentioned previously would address gaps in the MSIS and could allow CMS to re-assess the need for sources such as the CHIP enrollment that's currently reported in SEDS, and again, the EPSDT measures that are required in the CMS-416.

The documentation of inconsistencies between these data sources would also be important. For example, looking at the expenditures in MSIS and the CMS-64 would highlight relevant payment and financing issues. For example, folks have spoken at these meetings about supplemental payments, which are of interest in thinking about the implications of payment levels and methodologies on access to care. Since these payments are sometimes made out of a state's normal claims processing system, they're just one source of potential discrepancy between the claims level data in the MSIS and the information that we have in the CMS-64.

A fourth option the Commissioners might want to consider is encouraging CMS to collect and disseminate information on state program characteristics in a more structured electronic format that allows comparison across states and linkage with other data sources.

More structured and readily accessible state program characteristics could allow the Federal Government to better meet

its program oversight and integrity responsibilities; allow states easier access to policies that are in place across the country so that they could look to each other for models, as you heard about in our previous session; and they would also help researchers better identify the effects of various policy levers on enrollment, expenditures, and service use.

For example, knowing when co-payments were instituted, when benefits were changed would allow a further parsing of these enrollee experiences that we see in the enrollment and claims data.

The final option I want to mention is encouraging the appropriation of resources for CMS and encouraging the use of enhanced match for states under current law, recognizing that some of these options could require additional resources.

In particular, options three and four could require substantial federal resources and might not be possible to implement with additional funds. We seem to be in a world where funding is difficult, but this is something to consider.

Options one and two could require some states to alter their Medicaid and CHIP data systems, and there are some ways for those costs to be matched at higher federal reimbursement. Under Medicaid they might be eligible for 90 percent and under CHIP they might be

eligible for the enhanced reimbursement that's provided under that program.

Again, we're in a difficult budget environment right now, but these data are important for a number of reasons, not only for policy analysis, but also program management and oversight. GAO has recommended in the past that CMS make use of the MSIS data when they examine the CMS-64 expenditures. There's also been some questions about the usefulness of the CMS-416 data for EPSDT, which could be expanded and improved upon using the claims level data.

The HHS Office of Inspector General has strongly recommended the collection of encounter data at the federal level, and CMS has acknowledged a need to get a better handle on the services that are provided under managed care.

As a final point on the issue of federal administrative data, I think it's also important to emphasize the value of this data for states as well. States run these programs, but they also rely on support and guidance from the Federal Government. And to the extent that folks on the federal side, both Congress and the Executive Branch, have good information about what's happening on the ground in states, we're probably more likely to get better federal policies feeding back into the state world. And that's all for now. I look forward

to your comments. Thank you.

CHAIR ROWLAND: Thank you, April. I think our goal here now is to decide whether this is an area that we want to pursue and whether these are some of the options that we want to put on the table. So I'd welcome some comments. Trish, do you want to kick off our discussion?

COMMISSIONER RILEY: I think it's unequivocal that we have lots of data dumping and not much information. But I think before we leap to recommendations, at least for me, I again want to step back and say, what questions are we answering and for whom, and I would hope that any kind of recommendations would not be -- would be the states and CMS working together to figure out both the accountability needs and the administrative and management needs, and recognizing the politics that sometimes states don't want all this information out there.

On the other hand, they often want more timely data than Kaiser makes available that compares states because oftentimes in a legislative forum, that's the place to be. You want to see where you stand next to other states, unless you happen to be the most expensive state in the country, and then not so much.

There's also a context for this deliberation that I think

is important for the states. This is an important critical piece of work that has to be done. How we do it collaboratively, when we do it, and I would start with number three, consolidation, what we take off the requirements before we think about what we add.

Think about where the states are right now today. They're moving to ICD-10, which is an interesting activity, trying to figure out meaningful use, confronted with the issues around exchanges that are wonderfully exciting but very complicated, around how to interdigitate Medicaid with the exchange. Big, big issues. At a time when there's less and less staff and more and more constraints on the budgets.

In the exchange, your idea about the 90-10 match is a great one and in the exchange they just did it, but if you can't find -- there's no money. Finding 10 percent match is as hard as finding 100 percent funding. So 90-10 was a great move by the feds, but not if you don't have a penny to put into it, and that, I think, is where most states find themselves.

So I would say we need to start with sort of a go-to-baseline. What do we need to manage the program? What do we need to be accountable? What's the bare minimums we need and how do we get those? How are they related to other payers, because we're

living in a world now -- and we do have an all-payer claims database and I'd be happy to talk about how complicated that is and how frustrating getting scrubbed clean data in a timely fashion is. But it's important.

But we're working in a world in which more and more of us are talking about payment reform, reforms across all payers, and before we ask -- when you're reporting on provider activities and claims, the more you can make it look like how other payers report the more likely you are to get compliance, accurate data, and useable data at the state level.

I think that's a different place where we're so frustrated with our lack of good Medicaid data we go right to sort of how do we clean up what we have. I think it's an opportunity lost if we don't think about it in a broader environment, and ultimately, dare I hope, the ability to take administrative and clinical data and match them.

CHAIR ROWLAND: Mark?

COMMISSIONER HOYT: It's sort of tagging onto one thing Trish said at the end, how we improve what we've already got. So EPSDT periodicity schedules have been around for decades. Would it be worthwhile saying something about that? Is that data any good? Are there penalties to states for not meeting the markers by age? What

are the consequences to a state if they have poor EPSDT results?

COMMISSIONER RILEY: [Off microphone]

MS. GRADY: Well, first of all, I think states are allowed to vary in the periodicity schedules that they set, and report those schedules on these forms and there is some tracking of the progress in terms of meeting those periodicity schedules. However, I'm not aware of any sanctions or --

COMMISSIONER ROSENBAUM: The specific sanctions for EPSDT performance actually were repealed in 1981. It would be a compliance issue were children to receive fewer than all required services, but that's such a given thing for all Medicaid beneficiaries that it's not, you know, there are all kinds of services that are required services that people don't get.

So it's not so much a compliance issue, and the problem, I think the more serious problem, has been -- there are two issues. One is that there is some question about the periodicity schedule itself, so everybody has always been a bit skeptical about the periodicity schedule. And then the other is after age one, the whole system falls apart for children. You just look at these numbers and you can't believe it, how bad the drop-off is.

So I think the, to me, the core issue is getting a fix on

what's happening to children at key developmental points in relation to how they're using Medicaid services that would be relevant to child development without worrying about the periodicity count, which is where I think the CHIPRA quality measures may be more important to the extent that they capture some of this.

So that's a really good example of where you could have this data, but it's not clear that it's telling us really what we need to know about the quality of pediatric care.

COMMISSIONER HOYT: I think the schedule itself has intuitive appeal, kind of makes sense. It's sort of like wellness for Medicaid kids. But we've been doing this for decades now. What are we getting from this? If it doesn't work, stop, quit doing it, fix it or stop. I mean, it's not, in my mind, quite as important as encounter data.

CHAIR ROWLAND: I think it's a bigger problem than the data.

COMMISSIONER ROSENBAUM: Well, but this is also -- I mean, there's an underlying issue here which I think is worth raising at this point. So the periodicity schedule has this side to it that's all this data, data, data, data and data may not tell us anything that valuable.

In states with restricted Medicaid programs, though, the

entitlement to coverage for diagnostic and treatment services is tied by law to a periodic or an inter-periodic exam. Now, CMS has been quite good over the years in interpreting the entitlement broadly, so that they will count almost anything as a periodic or inter-periodic exam.

But literally, the scope of the coverage gets driven by the screening exam. So it's more than just -- this is going to come up for us again and again in Medicaid. It's more than just a data problem.

It is -- the way the statute is structured, the range of coverage gets driven by some of these things and so, if we're going to make a recommendation about not doing -- not collecting certain data, that's one thing. But saying that the service is not needed is sort of this weird problem, which is it may not be needed except it's needed because of the way the statute is structured.

CHAIR ROWLAND: Sharon?

COMMISSIONER CARTE: Addressing Mark's issue of like fix it or leave it alone, some of you may be familiar with the fact that HHS, the OIG, did a study of EPSDT across states earlier this spring, and unfortunately, it showed that as many as 40 percent of those children were not getting at least a hearing or a vision screening.

I, for one, have a really big problem with when we have a health care delivery system and we have an EPSDT B you know, being in a separate CHIP, I don't even like to talk about EPSDT. I don't think it really has much connotation to people, on average.

We should be talking about preventive wellness visits and if they accomplish something for children. I really don't think it should be the education system be left holding the bag to make sure that kids have had their vision and hearing checked before they come into school. It's a major failing of the health care delivery system and of our ability to report on whether or not we're doing that effectively. So it's a key issue.

CHAIR ROWLAND: Donna?

COMMISSIONER CHECKETT: I'd like to go to, I think, Slide 5, which is on the point on the Medicare Managed Care Data Collection System, and just ask for us to continue as a Commission to explore what does CMS have now from States on managed care. I can tell you from having worked in at least ten different States trying to manage Medicaid plans, we're turning everything into the States and the States are using that data to set rates. Now, if there is a single motivating theme to everything we've talked about today, it's that people do things for money. So health plans --

[Laughter.]

COMMISSIONER CHECKETT: They do. Doctors see people for money. It's true. Medicaid plans have a vested interest in turning that data in. So it's going to the States. States are using it for rate setting. It goes to CMS. I'm amazed to hear that CMS says they don't have data on what's going on in Medicaid health plans. They should get utilization data. They should have rates. So I would really like to delve into this and find out what's going on.

MS. GRADY: Specifically regarding the encounter data that all plans are submitting to all States that have capitated managed care right now, that's the finding, so all plans are providing it to States. The issue is that not all States are then passing that on to the Federal Government, and I believe that the OIG found that of the 40 States with capitated arrangements, there were 15 that were not currently submitting that data through the Medicaid statistical information system.

COMMISSIONER CHECKETT: So my questions would be, who are they, why aren't they doing that, and what is CMS doing with the data that they have?

CHAIR ROWLAND: And what -- do we need to also get into the level of what data is it? I mean, it's not all encounter data, but

what is it that you're really trying to answer as the questions with the encounter data. What do you need this data for?

Sharon, you had another comment?

COMMISSIONER CARTE: I'm sorry I didn't bring this up at the previous session when we had CMS staff here. We were talking about the reporting of administrative data, April. But it might be worthwhile for somebody to have a conversation with all the perm contractors who work with the State because I think that they saw at that time probably a pretty good cross-section of what the reporting difficulty issues were and could give you a lot of feedback about that.

CHAIR ROWLAND: Robin?

COMMISSIONER SMITH: I have a question about the EPSDT again. How do we know that the failure is with the State not providing the service as much as the families not taking advantage of the service? I mean, like from birth to one year, it is frequently tied into WIC. You go to the clinic, you get your check-up. So how do we know that it's not the States -- I mean, it's not the parents at times or the families as opposed to the States not supplying it?

CHAIR ROWLAND: I think you've just raised an incredibly important issue to look at even for access. To what extent is access

available and not utilized as opposed to not available. I think that goes beyond the data requirements but it's a piece, and trying to measure it, it's a huge issue. That's a great point.

MS. GRADY: And I'll just speak to Donna's comments. So we do know who, which States, and I think Sharon's idea about talking to some of the contractors who've been looking into the data for the payment error rate measurement purposes could be very useful.

In terms of how CMS is using the data they do have, it really has not been used until this year, essentially, and last year. CMS has a contract right now to look at what they have, try and assess the quality of what they have and go back to the States and work with them and see how this information might be useful.

And Diane, you also raised the point of, again, why is this information important? What would we want to do with it? And, you know, for example, as I mentioned, we might have ways to learn about preventable emergency department visits, just looking at crude sort of rates among the managed care and the fee-for-service population to get an idea of whether some States are particularly successful in that area or not. And just having a sense of how utilization differs between these populations is something, again, we might have a handle on at the State level in some cases, but not nationally and States

don't have a good context for where they are. Trish mentioned sometimes they really want to know how they're performing against each other. They want to have some benchmarks and there's not a whole lot available right now.

CHAIR ROWLAND: Patty, did you have a comment?

DR. GAYNOR: Yes. Do we believe that the reason why the Medicaid data -- well, I guess I would step back and say, do we know if Medicare data is much better than Medicaid data in its utility, in driving decision making? And if the answer to that is yes, is the sole reason why we don't have that in Medicaid because it's a State feeding the data to the Feds issue, or are there other variables that are important?

CHAIR ROWLAND: Do you want to answer it, April, or --

MS. GRADY: I'll take a shot and then I'll be happy to hear other people's comments. I do think a major part of the issue is that this is a State-run program. States have their own systems, although many of them do contract with a small number of vendors. That does create some uniformity in the process, but still, they have their own formats, in some cases their own codes, their own local practices for having providers submit bills and their own processes for payment.

So what the States have to do is then take the way they

do things and transform it into this separate Federal format that's standard across all States, and that takes time and that takes effort and that takes staff. Part of the delay is just in that transformation and part of the difficulty is in that transformation from what it looks like at the State level to what the Federal Government is asking them for.

COMMISSIONER ROSENBAUM: [Off microphone.] Can I ask a follow-up question to that? So the part I don't understand -- and I'm sure maybe I'll get killed for asking this question by State people -- so why hasn't the Federal Government ever just simply -- I mean, the MMIS systems are predominately financed federally. Why doesn't the Federal Government just take the data and then claim the data federally? Why do they wait for States to take the data, do what they're going to do with the data, send the data? Has anybody -- I mean, is this, for example, the way MSIS works, where the Federal Government just takes the data? I've never understood.

No one is going to -- I mean, if you look at the discussions around electronic health records, nobody is expecting, really, that it's going to be sort of a decision on the part of -- they may be saying it, but a decision on the part of providers, what data to send on. I mean, there will be a data use agreement and it will be

understood. If you're paid by Medicare, the data are going forward. So why has this not been an issue in Medicaid?

MS. GRADY: I think it's a good question I don't necessarily know the answer to. Lu seems to be -- no?

EXECUTIVE DIRECTOR ZAWISTOWICH: Twitching over here. You know, it's just the history of CMS and then HCFA, where there's never really been an interest in collecting those data. I mean, traditionally, Medicaid -- the review process of Medicaid was really one where you're looking at standards and processes and not really looking at data, and it's really the history of --

COMMISSIONER ROSENBAUM: So it's just custom?

MS. GRADY: It's just custom.

COMMISSIONER ROSENBAUM: It's custom.

MS. GRADY: It's just custom, yes.

VICE CHAIR SUNDWALL: Let me just give you a State experience on -- it might account for some of this. Our Medicaid agency is surveyed to death. I think you said the sources of data are the all-payer claims data and survey data. Our CFO for the agency says we really ought to rename the Utah Department of Health "Surveys 'R Us," because if you count CMS, regional, legislative audits, State auditors, plus -- it goes on and on. And so I guess there might be

some factor of survey fatigue or data dearth -- not a dearth of data, but a dearth of people willing and able to comply with the many requests.

So I think -- first of all, I want to applaud you for your presentation because I was very pleased to see in our very first report we are going to have a section on data. Most of us really cherish the notion that policy is made on information and evidence, not philosophy or politics. So this is what grounds us, whatever your party. We are grounded and I believe that reliable information should drive our recommendations. So that is really essential.

And I think in our report, Lu, we ought to say that right up front, that the Medicaid -- the MACPAC is going to be evidence based, data driven, and so we are expending time on this stuff, which might seem boring to some, but it's really essential.

Now, if I understood it, your options to consider list things which are a menu and you're looking for guidance from this Commission to tell you where we ought to invest our initial effort. I would make a case for not being so much in the weeds that we talk about EPSDT or ESRD, for that matter. Of course, that's Medicare. But anyway, just make it on something that would be apparent to readers of this kind of better information is useful as we go forward with

Medicaid.

And also, I really like what Mark said about, for heaven's sakes, if something hasn't proven useful, could we be so bold as to say, don't do that anymore? It would be welcome on the part of many States if there are some things that we're spending time and effort on that haven't proven to be very effective or useful.

CHAIR ROWLAND: And I think certainly tomorrow we're going to talk about the complement to program data, which is survey data, and what can you answer with program data versus what do you answer with survey data and how do you make the two mesh. As we know, right now, survey data often comes up with very different numbers than program data.

But Mark, you had a comment.

COMMISSIONER HOYT: Just one follow-up comment on EPSDT, more as an example than just being fixated on that for the sake of that data alone. You know, we have MLR requirements on that. We have concerns about administrative costs at the plans --

CHAIR ROWLAND: That is medical loss ratio requirements.

COMMISSIONER HOYT: -- expenses that plans incurred. If there's anything that drives providers and plans crazy, it's reporting requirements for things that either aren't used, or in the case of

EPSDT, I've certainly seen, and I'm sure other people have, that managed care gets a black eye as being bad because EPSDT is inferred to go down when you contract with managed care plans, which I think is a false negative.

The one other comment I wanted to make real quick that we've seen about -- it wasn't the number one or two thing, maybe, but providers make decisions on whether to participate in Medicaid based on the hassle factor and administrative requirements, and so if we're going to require them to report every EPSDT encounter or other encounters, for that matter, I think it's imperative that we both use it for something constructive and that eventually gets fed back to them so they could learn something from what it was they reported. Otherwise, that's the hassle factor that they hate.

CHAIR ROWLAND: So now you're linking all the pieces of our report together. Very nicely done.

I think the other point that our recommendations, when we get to it, ought to speak to is the timeliness of the data, because certainly one of the big problems here is that it may be usable data, but if it's three or four years old, it may not be very relevant to the decision going on today, and how do you get really timely data and is that a subset of the bigger databases that you get or whatever.

Judy?

COMMISSIONER MOORE: Before I get to my main comment, I would just say, it was only, I think, 12 years ago that there was a requirement for States to provide the data that now is put into MSIS. In 1965 and 1966, there was a basic decision made that there would not be a requirement for States to submit data the way it was with Medicare. And the path of least resistance has always been to let the States do whatever they wanted and there just wasn't the will to do that, which kind of leads to my thought about the potential for recommendations and our options.

Because CMS did make a presentation with us, before us, and told us the things they had underway already, I think it would be probably even helpful to them if we encourage some of their consolidation efforts and encourage them to do some more collection and dissemination of the existing information that they already have. They are obviously on that track already, and other things will come along, and maybe with a little push from us, that will continue to encourage them to go that direction. So at the very least, I think that we should be thinking along those lines.

COMMISSIONER WALDREN: Well, I mean, just a couple of things. One, to Sara's point about the EHRs and the reporting, that

that's exactly what they're doing. They're defining the format, and that's actually multiple formats. There's the PQRI format for Medicare. There's a QRDA format, and I don't even remember what those acronyms mean B

[Laughter.]

COMMISSIONER WALDREN: -- because they're irrelevant, because they're not going to be used moving forward.

One of the things, I think, with the data is, I think one is what data do we have and what can we mine, and then I think also having a data strategy, saying as we move forward as MACPAC, what is the data set that we need to really inform Congress for them to make the hard decisions that they need to make moving forward, and as we think about those, how do we get those as close as we can to transactional?

One of the problems that I see in the EHR world is that when we start talking about all these measures, they started out as administrative data because that was the data that we had. But they had the -- I think the problem they made was they did not make the change to clinical data, to actually data that can actually drive some hard decisions, and they take the same process that they did for the administrative data and put it onto the clinical data and

I think we don't want to do that.

So I think if we separate it out and have two strategies, one that is this is the data that exists, and I like the idea of saying, what can we mine, what can we value, and what can we devalue to get rid of, because there are going to have to be more reporting requirements on more clinical data and more transactional data if we are going to get to our early warning system and the stuff that we actually need to answer some of these very hard questions.

CHAIR ROWLAND: It sounds like a good set of criteria for evaluating some of our options.

Judy, did you have a -- or Robin?

COMMISSIONER SMITH: No. I'm sorry.

MS. GRADY: One point I just wanted to make, because there has been some discussion and it seems like support for consolidation, if nothing else. Part of the issue is that if you eliminate, say, the EPSDT reporting, it's not clear what takes its place because the other data sources don't overlap completely. And so one of the issues is that these options are a little bit interdependent in that if we don't have encounter data, we don't have anything to replace the 416 if we get rid of it. And if there's a decision that it's of no value whatsoever, then, you know, it could be scrapped. If it is of at least

some value because there's nothing else, we have to think about the interdependence of some of these options, and we can talk about that further.

COMMISSIONER ROSENBAUM: I think the other thing that's really a problem, and I have long felt this about the EPSDT data, which is another -- and it goes right to Robin's question -- if you look at the EPSDT data, what you would think is that low-income families don't use care. In fact, if you look at one of the survey sources, the MEPS system, which I assume, or NHIS, one of those things, whatever they're called -- we'll talk about it tomorrow, I guess. But if you look at those surveys, what you see is that low-income families use health care almost exactly the same way that other families do.

So then the question is, well, why, and the answer is because, in most States, you can bill for a preventive service for a child either as an EPSDT screen or as a well child exam. And so there's tons of well child care of varying quality, just like the EPSDT screens are of varying quality going on. And what we have in these problematic data systems is not just a burden on providers, as Mark is pointing out, and inconsistency and incompleteness, but it leaves people with the sense that families are inappropriate users

of care. And I think, you know, we find that the data then actually do harm. They aren't just not good, they actually do harm.

And so I think that the urgency of not only recommending better data but recommending stopping certain data that create a misperception, particularly of beneficiaries, I think is very important here.

CHAIR ROWLAND: I am hearing some issues regarding the options that have been laid on the table and I'm wondering whether the strategy that the Commission wants to follow is to more directly link these options to the questions that they seek to answer and maybe to roll a few of these together so that you would come back to us with a set of recommendations that build on these options, but that are really very specific to answering the question. And we're hearing a lot about consolidation, a lot about being careful about the administrative burden of even collecting it, making sure that the data is used. So some examples such as we have heard today would be very useful to have, as well.

Does that work for you, April?

MS. GRADY: It does and we will be working on that.

CHAIR ROWLAND: Okay. I think now we will take a ten-minute break and we will come back.

[Recess.]

CHAIR ROWLAND: Okay. If we could please reconvene. We've had a very productive and fruitful day so far, and as we come to this discussion, I hope that we will be as excited and enthusiastic as we have been with the others, because I think it's a very critical area for access to care, and I'm glad that Burt Edelstein could be with us at this Commission meeting because I know this is an issue near and dear to his heart.

What we're going to look at over the next few meetings and begin today the discussion is how to assess access to dental care for children in Medicaid and CHIP. Genevieve Kenney, our senior fellow with the Urban Institute, who has been our senior advisor, is once again at the table to help us with an access issue. But we're especially pleased to welcome Dr. Mary McIntyre, the medical director and deputy commissioner of clinical standards and quality at the Alabama Medicaid Agency. So we're very pleased to have you, and we also promise to get you out of here in a timely manner because for all of us this has been a long day, but we also know that there's a Christmas tree lighting going on at the White House, and so there is likely to be some heavy traffic for the 5 o'clock lighting.

Okay. So start us off, Jenny.

ADVANCING CHILDREN'S ACCESS TO DENTAL SERVICES

OVERVIEW

DR. KENNEY: Thank you, Diane.

I think this discussion coming late in the afternoon fits really nicely with the discussion that we just had about EPSDT and data issues. I'm going to be sharing an analysis that was done jointly with Stacey McMorrow, who is here today from the Urban Institute. I'm going to provide a brief background on dental access issues for kids in Medicaid and CHIP, touch on what we know about what policies affect access to Medicaid and CHIP, and I'll close by presenting some potential options for Commissioner recommendations in three areas.

Briefly, why dental? Oral health issues, many of you may or may not know, constitute the most common chronic health problem facing children, and that's despite the fact that they're highly preventable. And untreated oral health problems in children can lead to costly emergency room use and hospital stays as well as to school and social problems, and in rare but really tragic instances death.

Rates of untreated decay are highest among low-income children, and, in fact, oral exams -- so not dependent on parental report, but oral exams conducted between 1999 and 2004 found that a third of children with Medicaid and CHIP had untreated tooth decay

and that 5 percent had an urgent need for dental care. So this is an area where unmet needs have been documented.

That said, our analysis, which attempted to synthesize what's known on this topic, is that there's clear evidence that Medicaid and CHIP have demonstrably improved access to dental care for children compared to what they experience if they lack coverage altogether. But when the comparison is made to privately insured children, the access for Medicaid and CHIP kids isn't quite so positive. It's a more mixed story.

It's important to point out that children of racial and ethnic minorities, children living in rural areas, and those with special health care needs often face the greatest access problems, but equally important to point out that those problems are not unique to children in Medicaid and CHIP and that they're found across from payers.

Just last week, the GAO released a very important congressionally mandated report on oral health that covered a number of important topics listed there. But what I want to do is highlight some of the important findings from that study.

First, in many states most dentists were reportedly serving few or no Medicaid children or CHIP children, and so the question

of dental participation in the program, which has been studied going back to 2000 and earlier, persists. And the study also pointed to the fact that the low participation could have particularly adverse effects on kids with special health care needs.

Second, a new website that was mandated as part of the CHIP reauthorization bill, the Insure Kids Now website, that contains information on dental providers in each and every state, Medicaid and CHIP, was found to have a number of inaccuracies by GAO when they went and tried to contact the dentists that were listed in a subset of states. And so real questions were raised about the usefulness of that information.

Third, while improvements in Medicaid dental service use have occurred across this last decade, rates are still very low of just receipt of any dental care as reported by the famous 416 that April just walked you through. And, importantly, there were data gaps, as April indicated, with respect to managed care that lead to issues managing the program.

Then, finally, the report addressed variation across the country in scope of practice for dental hygienists and also looked at the experiences, which are mostly outside the United States, using mid-level dental providers and found positive experiences, but,

again, there's almost no experience with this in this country.

The report raised a number of questions that point, I think, from the MACPAC perspective to the need for more analysis, and I know that's a "gimme" coming from a researcher.

[Laughter.]

DR. KENNEY: But, really, we don't have good research on the effects of state variation of scope-of-practice laws, and there's a lot of variation there on access or costs in Medicaid and CHIP. There's a real gap. And then, second, we don't have comprehensive or a strong body of research that speaks to the question of the impacts of dental managed care on access and costs in Medicaid and CHIP.

Our analysis suggests that there are both provider and beneficiary issues that are impeding access. First, on the provider side, there are general shortages of dental providers, and that's particularly acute in the low-income areas where so many of the Medicaid and CHIP beneficiaries live. HRSA has designated 4,000 dental health professional shortage areas and estimates that it would take 7,000 full-time equivalent dentists additional to close those gaps. So that gives you a sense of the general problem that exists.

VICE CHAIR SUNDWALL: Jenny, I just can't help inserting here that if you ask the Utah Dental Association, we have no shortage

at all. So we need to always keep in mind the public health assessments versus that of the profession, which are clearly difficult.

DR. KENNEY: That's such good point. So let's come back to that. I think that's a good point.

When we look within Medicaid and CHIP, there are additional questions and issues. With respect to managed care, a 2009 GAO study documented issues with network adequacy and standards in some states. And on the fee-for-service side, low payments to dentists are repeatedly cited as a barrier by dentists. And we don't have a Medicare analogue, and the only data that we've found for every state suggests that Medicaid on average was reimbursing at about 60 percent of median charges, and there's some question as to what commercial rates are, but they seem to be above 60 percent of median charges.

In addition, some states have cumbersome administrative practices regarding prior authorization, enrollment verification, and payment that reportedly deter dentists from serving Medicaid and CHIP kids as well.

You're going to hear from Dr. McIntyre on Alabama, but a number of states' experiences suggests that combining increased payments to dentists and reducing administrative burdens leads to both increases in participation among dentists and in the share of

kids receiving any dental services.

On the beneficiary side, research suggests that many families are not always aware of the availability of dental benefits of Medicaid and CHIP. I think we take for granted that it's a core benefit for kids, but there seems to be a gap in family awareness of that.

There are issues with respect to their belief about the importance or understanding of the importance of oral health and ongoing dental care. And not surprisingly, given some of the participation issues, families have difficulty finding dental providers who will treat Medicaid- or CHIP-covered children.

And, finally -- and this is an issue where I think we don't really understand the root causes, but providers repeatedly report that missed appointments are a problem, and so families are having difficulties getting to appointments in some cases. Whether that's related to transportation or work barriers, we don't know, but it's an issue.

So our analysis suggests that there are really three keys to improving dental access for children in Medicaid and CHIP: first, need to address the shortages in available dental services; second, need to increase the number of providers who are both able and willing

to provide services to Medicaid- and CHIP-covered kids; and, third, the need to increase both the interest and the ability of families to take advantage of the available services that are there in Medicaid and CHIP.

So the Commissioners, with that as background, are asked to consider potential options for recommendations in each of these three areas and to provide guidance on which areas warrant further analysis to support the development of specific recommendations for Commissioner consideration in the future.

Under possible options to increase the overall supply of oral health services for kids, first, states could consider expanding state scope-of-practice laws for dental providers. Second, Congress and the Secretary could support demonstrations to evaluate the use of new dental provider types, as called for in the Affordable Care Act, but with a focus specifically on how they would affect children covered by Medicaid and CHIP. Third, Congress and the Secretary could support research that examines the impact of non-dentist providers on access and quality of oral and dental health care for kids and the service costs associated with alternative provider mixes.

Turning to possible options that would be geared toward increasing the provision of oral health services to Medicaid and CHIP

kids, states could examine whether their Medicaid and CHIP programs support the use of licensed dental providers to the full extent of their scope of practice under current law in the state. Second, states could evaluate the adequacy of payment rates for dental services under Medicaid and CHIP. Third, states could adopt a comprehensive approach to limiting provider administrative burdens. And the Secretary could support those efforts by making available to states options for how to reduce administrative burdens. And, finally, the Secretary could examine dental network adequacy requirements in managed care and perhaps suggest guidelines or follow-up when there appear to be problems with networks.

In terms of beneficiary issues to improve oral health literacy and support beneficiary access to dental care, the Secretary could identify and share effective state and other stakeholder outreach strategies to beneficiaries. States could consider using existing case management mechanisms or services to assist beneficiaries in making and keeping dental appointments and obtaining needed transportation. And the Secretary could provide states with information on successful existing case management models under EPSDT for dental care and provide technical assistance on implementation and reimbursement.

So I'm going to close with that and say to the Commissioners that we very much look forward to hearing your input on these issues, and I'm going to turn to Dr. McIntyre for her to tell you about the very important policy changes and progress in Alabama.

INNOVATIVE STATE PRACTICES

DR. McINTYRE: Thank you. I am going to actually use the slides up here, but while he is doing that, I did want to start with -- you're going to hear some recurring themes, and I promise you I haven't seen Jenny's presentation. So you're going to hear me repeat some of the things she has talked about just from the standpoint of what we've gone through. Okay? And I wanted to start with the point that you see on the first slide that I am not a dentist. I'm a physician. I'm actually board-certified in preventive medicine, and how did I come about dealing with oral health and being kind of like the Alabama guru from the standpoint of being in the trenches and trying to get access for children because of EPSDT services and having no ability to actually do that. And then I ended up coming to the Medicaid Agency, only to be the one that had to try to figure out to solve the problem.

What is Smile Alabama, the Alabama Medicaid dental program? I wanted to start with the fact that the Smile Alabama initiative

has become synonymous with the Alabama Medicaid dental program to be one and the same. Basically I'm going to do a very quick overview of this program. I did provide slides, a lot of slides that I actually had for this presentation, probably 40-plus, but you're going to get a very quick overview. But if you want more information, they're available in the slides that I provided.

One of the things you need to understand about the Medicaid dental program is we don't have health plans for managed care. We provide fee-for-service for the dental program and really most of our Medicaid program. We have a PCCM called Patient First program, but we basically -- somebody asked, well, we didn't bring a vendor in to do this. We had to do it ourselves. So Smile Alabama is a public-private partnership and continues to be a public-private partnership. And we basically started and put a team together and came up with a plan, and then we had to try to figure out, well, now we have a plan, how do we pay for it. So that's how the dental outreach initiative was born.

We ended up with the funding that we identified, we actually went out on the Web, believe it or not, and we looked for any grants that we could apply for that they did not say that a state program couldn't go after and then that we could actually design something

to put in, some requirements, and that's how we actually funded the program.

We had two primary goals that we identified for the 21st Century Challenge Fund, Robert Wood Johnson program, and these are those two, to actually increase the number of participating Medicaid dental providers -- and you'll notice specifically participating, performing, not enrolled -- and then to increase by at least 5 percentage points the CMS annual dental visit rate by the end of the three year grant.

So this is where started identification of key individuals that we really felt were really necessary to be at the table in order to for things to happen, and we actually ended up expanding this, and we actually ended up with more than one group before this was all over with that continue to meet today.

And so we listened, and in the beginning there was a lot of yelling. I tried not to yell. I tried to be, you know, really calm and quiet, but it didn't always work out that way. But we had to deal with each other and listen to the complaints coming from the other side that we were intentionally not paying them so that we wouldn't get the money out, that it would stay in our system. And so there were a lot of things that we had to get around. But we ended

up actually looking at data, and we listened to what the issues were that the Dental Task Force said. And then we went out and tried to see if we could back up that information with a series of surveys.

What we did is indeed within one year -- and you talk about survey fatigue, but we actually tried to address what we called the Medicaid-enrolled dentists only, those who actually were still enrolled. Some of them were not performing. They were not providing services. And we actually used our Alabama Dental Association, and they in their newsletters and to their groups sent out a survey for us, and we then worked with the Health Department, and we sent a survey out to all Alabama licensed dentists.

The surveys were not exactly the same. They started out more basic and then expanded as we went along to get more information. But one of the things that we learned, the first slide that I showed a minute ago was about reimbursement being really an issue. But number two and number three dealt with the whole claims process and how difficult it was.

Then we learned from the second survey, which was the AlDA one, that one of the things that the dentists were most concerned about was about missed appointments and that patients did not keep their appointments and they didn't know why, and about what were the

limits for the Medicaid program, what was covered, and when was the patient responsible for the bill, and who would they call if they needed help with Medicaid eligibility.

So the plan that we came up with started with, number one, claims process and simplification, and we started there because we knew that we needed to -- we considered the dental rate increase an enabler, but it was not the only factor based on the surveys that we had done. Some of the responses that we received included, "There is no payment you could ever pay that would make me see a Medicaid recipient," to "I don't take any insurance. I consider it a discounted rate, and I do not accept discounted rates." So it wasn't just a Medicaid issue. It was an insurance issue. They wanted payment in full for whatever it was they billed.

So we started where we could, which is with the dental claims process and simplification, because we had heard loud and clear that it was complicated, and I read the manual coming in from the outside brand new and realized that I had to read the thing multiple times to even understand what we covered, when was it covered, how much did we pay, which was nowhere. There was no fee schedule that a provider could get access to to know what they would get paid. It was complicated to know if they had a problem, then who did they call.

You know, "Where do I call if I can't get my claim through?" So there were a lot of simple things like putting a single sheet that went through individual steps, if this occurs this is what you do, and getting the information out, simplifying the provider menu. And Dr. Conan Davis was there at the time, and we worked through simplifying the menu to the point that with a lot of the people in the dental offices, we knew that they were not -- they were high school graduates. They were sometimes in the front office. And if I could read it three and four times and didn't understand it, then we knew that they wouldn't know how to get a claim through the system.

So we did things like put together a little single sheet that showed them what to do when you got a specific error message, what it meant and how to get the claim processed, because one of the things they said, "If I could just get paid for what I do, even if you didn't increase the rates, I would be happy." But the dental rate increase was seen as a way to get us through the door. It was an enabler.

So what we agreed to do was to continuously work on trying to get the rates up while we dealt with the other problems. Provider outreach and identification was identified as being extremely important, and consumer and patient education.

So how did we do this? And I'm going to -- this is just an example of the strategies. There are a huge number of sheets, and this just kind of looks at the fact that you have to deal with diverse providers, not just dentists. You have to deal with diverse stakeholders in order to get this done. We went everywhere with everybody trying to identify how could they assist with the problem and how could they -- what could they do. So this is just some examples.

We worked with primary care physicians to get them involved in the initial process, and we recently revamped that to provide a requirement for a risk assessment and a referral within a certain time frame for children.

Then we had OB/GYNs. Mothers needed to be taught what they needed to do with their babies prior to birth, and they were more likely to listen during the care coordination visit before their baby was born. So that was a component. So that's the obstetrical intervention.

So what kind of results did we end up? And this is my little slide rule. It's not starting exactly where we started. The program itself, the initiative to begin February of 2001, really we started in 2000 trying to get some of the stuff on the ground work done to

make it work. But from 2003 to 2010, you can see what's happened as far as our utilization. We actually started with a dental utilization rate of 26, okay? And we're now at 44 percent as of our last number. So you can move the percentages.

Now, enrolled and performing dentists -- remember when I started and I said enrolled is one thing, but you have to look at participating numbers. If they're in the program and they're not seeing children, they're not going to help you. Okay? So a lot of people and a lot of the information we saw looked at the enrolled numbers, but you really need to see are they performing, how many children are they seeing, and how many of those providers are seeing more children. We actually started our focus with those providers who were enrolled but not participating to try to get them to participate. Then we went out to people who were not participating at all or enrolled, and that's basically the little targets that we set out to identify first.

And then we looked at how many of those dentists -- we actually looked at how many see at least 50 children, how many see 100 or more, and we tracked that on a yearly basis. My early indicator or warning sign is when I see a drop in the number of performing providers that are seeing greater than or at least 100 children.

That's my early warning sign, and you will see that we had a blip that really scared us to death because it was the first decrease we had seen with the numbers that occurred right in about 2009 with the actual providers, performing providers, seeing 100 children or more. And we tried to then go and see, well, what is the reason for this? What happened?

So what we actually were able to identify is there were a number of things that occurred in 2008 that impacted 2009. We dealt with issues with re-enrollment, the NPI. Some dental providers didn't get an NPI number. Some of the providers on the system that were seeing just a couple of children just decided that they were coming out. But they were not the ones we were worried about. It was the numbers that we were seeing a lot of kids that we were worried about.

So you have to have some way to know that you're getting into trouble, and actually the economy being as bad as it is has helped us, and I'm just going to say that. And the reason we're saying that is the numbers started to go back up because it's better to fill a dental chair with a patient where you're at least getting reimbursement at a level that's a little above your overhead than not to have a filled chair at all. So guess what? We got more children

in and started pushing our access back up because the economy is so bad, people delayed dental services. They don't go in and they don't pay up front. So we were actually able to get more children seen. So keep that in mind, okay?

[Laughter and inaudible comments.]

DR. McINTYRE: There are about, when you look at the numbers -- and it's going to depend on whether you're looking general versus specialist, and we talked about this. The number of actual Alabamans is around 1,500 -- between 1,500 and 1,800. We haven't looked this year to get the actual numbers. That's something I asked them to do in the last couple of weeks. But what we have noticed is that we're not growing providers. We're actually going negative. We're losing dental provider numbers, not in Medicaid but in the state as a whole.

So we are starting to slide backwards. Then there's probably some of the retirement and other issues coming in.

But what I want you to take a look at, we -- you know, the whole focus that we've had so far in this program is to get children in earlier. The earlier, the better. Our numbers from a utilization standpoint as far as eligibles receiving services are actually better in age groups for those -- you'll look and see where we are actually above the U.S. with those areas. But where we're not great at is in

that 19- to 20-year age group, and we're about equal in the 15- to 18-year-old age group. So if we really want to push up our utilization numbers, then we're going to go after that 19- to 20-year age group, okay. But we really felt we would get a bigger bang for our buck in trying to get children in for preventive care early.

So this is where we are, okay. This is our 2010 information as far as the number of enrolled. But what I want you to pay attention to is not just the enrolled number, but how many of those enrolled are actually seeing children. We have actually been able to pick up the participating number, and also that number greater than 50, greater than 100.

One of the things I didn't mention is how much this is costing us, is we started with $11 million and last year it was $82 million, and we talk about decreasing -- when you're looking at that, in order to take us from 44 percent, we went 44.05 percent in 2009. We went to 44.4 percent, but we went from $73 million to $82 million with less than a half-a-percent increase in utilization rate.

Why is that? More people, children eligible for services in the denominator, okay. It means that we had more children receiving care, okay, but if you look at the percentage rate, it appears that we really didn't move. We had a lot more children receive care, but

because the denominator itself is growing, we have more children being eligible, it doesn't reflect in the utilization rate.

So we actually do the HEDIS annual dental visit rate now. If we actually do it and exclude those children who are not eligible, which are the 21-year-olds, we have a 61 percent annual dental visit rate based on the HEDIS measure.

So what can be done, and this is where I talk to people about one of the things in the plan that the States can do is they can actually identify the key stakeholders and work together because this is not something that Medicaid can solve by itself. It is not something that a single entity can do and you have to use multiple strategies, okay.

And I wanted to end with the fact -- so I was asked to think about two questions and one of those questions was, so -- about if -- okay. What additional policy changes would be needed to raise the recipients of dental care further up to the recommended levels for Medicaid-covered kids and what could CMS do to help States improve access? So what are the answers?

Well, I don't have any specific ones, but the reality is that utilization is not just determined by provider availability. I think somebody mentioned this, the perception of importance of those

services and care, not just the perception of the services from the caregivers' standpoint but also on the providers that are involved in the program as far as the dentists. How important is it to them that this population receives care, and can we figure out a way to get everybody to play?

The reality is is that if we -- you know, it would be a whole lot less burden if more dentists were participating. It would take them -- they wouldn't have to see as many in order to get the children to receive the services.

So we're on the, what I call on the edge of the cliff right now, and I'm mentioning this because if we had to do this program today, the reality is that we could not. Everything, all of the stars lined up, you know. We were able to get money for the program and we were able to get a reimbursement rate increase. But we also had a budget that allowed us to get a rate increase to push our rates up to 100 percent of what the Blue Cross-Blue Shield rates were at the time. We've decided that in order for us to be able to play, we needed to meet the market, and for us, meeting the market was to get our rates equivalent to what Blue Cross-Blue Shield was paying.

Now, what did that mean? It meant that Blue Cross-Blue Shield cuts out. The patient has to pay a copay. But for us, it was

100 percent of that. So instead of that copay amount, whatever the other insurance was paying, and actually the fee would have been less, we took the whole amount on, and I think that's really part of what allowed us to be able to get our feet in the door.

So that's pretty much it, so I'm ready and available for any questions you would like to ask.

CHAIR ROWLAND: Thank you both very much.

Sara and then Burt.

COMMISSIONER ROSENBAUM: So I just -- Dr. McIntyre, my hat is off to you. I mean, it is really just an astounding effort that you have put together, and in a State that has just such serious medical under-service problems.

I have a question about financing the work that you did. So you were, of course, creative enough to go and find the RWJ grant. We should write you up as a testimonial to RWJ. I mean, I'm sure they know how great this is. But here's my question, and it goes to sort of an issue that we have to deal with here that goes beyond dental.

In the Medicaid program, there is a 75 percent Federal financial participation rate for services that require skilled medical professionals. Now, a major initiative to increase the accessibility, availability, and quality of dental care, to do what

you needed to do to get to the bottom of the problem, to design a solution, to get your utilization rates up, to me is the quintessential example of an activity that should be paid at 75 percent of the Federal medical assistance rate -- 75 percent FFP rate.

Have you, just out of curiosity, before you started your work, did you ever, for example, have discussions with CMS about whether they would support this at the enhanced Federal rate to get you to the point where you could have the resources to do this?

DR. McINTYRE: Well, let me tell you where the issue occurred. We didn't ask about it because we were only aware of the administrative rate, which is what we were told that we could do from our agency standpoint, which was the 50 percent for outreach activities. But the problem was coming up with the money for the outreach activities from the State level, okay.

And so what we had to do was we had to figure out -- and we actually -- when I said our partners, partners actually put in money to actually -- because the Robert Wood Johnson Foundation Fund was a matching funds grant which meant that we had to find the matching funds in order to do that. And then we took that money along with the matching funds money and we pooled the Federal match down, okay, which we did at 50 percent, because I'm going to tell you, the States

are hesitant to do things that they consider to get them into trouble.

And so they wanted to be -- and because we mentioned the fact that, well, we've got physicians. I'm out here running around. I've got nurses out here running around. Couldn't we get a 75 percent match for that? They were really hesitant in what they call sending up red flags. What they thought it would be better to do, the regular 50 percent of the money.

So we were actually able to take the $500,000 that we had and end up pulling down another $500,000 to get a $1 million outreach effort out there, which was really something that allowed us to put what we call Dental Outreach Specialists in the field to actually put people that were specific for dental, specific dental areas, so that what they could do, they knew who to call if they had a problem with getting a claim through the system. It allowed us to do some of those things that we wouldn't have been able to do. But it would help if States knew the potential to be able to do that.

But I'm going to tell you now, it's even coming up with the -- you know, I'm going to give you an example of what the issues are. I had to try to find money to get the HEDIS technical specifications, not a lot of money, but the technical specs. I ran into problems even finding $5,000 within the agency to pay for the

technical specs. So I had to do some moving around and some other stuff within the budget to get the money to get the specs to do the CHIPRA core measures. That's how bad it is.

We're looking at -- when I say we're falling off a cliff, we're looking at for 2011 we're losing the enhanced FMAP from the State standpoint. With Medicaid alone, it's over $60 million of a shortfall, and we are one of those really slim programs already, so we really have nowhere to go when it comes down to cuts, you know. We talk about our administrative percentage and how low it is, but how low can you get and really still be effective? And then what do you do when you've cut everything else that you can cut?

So the reality is that we actually were able to stop -- there was a dental reimbursement rate decrease planned for last year of ten percent, okay. We pooled all of the targets -- I mean, everybody came out saying, you know, that's not a good thing to happen, and we were actually able to get a Dental Subcommittee together and let them work through looking at the program and make recommendations for specific procedure codes and other things clinically from a standpoint of what care could be done and looking at specific codes. But we didn't cut the dental rates at all.

So how long can we fend that off? I don't know, because

2012 is even worse. We're talking about several hundred million, a couple of hundred million dollars from the Medicaid standpoint alone. So we have no idea where we are going or how we're going to be able to sustain the programs, and not just the dental program.

CHAIR ROWLAND: Burt?

COMMISSIONER EDELSTEIN: I think one of the things that Jenny could have added to her list of recommendations is to clone Mary.

[Laughter.]

COMMISSIONER EDELSTEIN: But at the end of the day, after Diane and Lu have worked us so hard, what I wanted to do is to take just a couple of minutes based on a conversation I had with Lu and Jenny yesterday and see if I could twist my fellow Commissioners' minds around some fundamental issues that relate to why we are taking this up and what is unique about dental that makes such a difference.

And I was sharing with Lu earlier that it's a historical accident that in the United States, dentistry is not a specialty of medicine. It's a 19th century accident in which the proto dentists were rejected by the first medical school because they came from the Barber surgeon's ranks and instead set up their own school, their own profession, and now we have a dichotomy between medicine and

dentistry that shows up in all kinds of places, including in the Baucus-Waxman letter that references physicians. In Medicaid, dentists are regarded as physicians, in Medicaid policy, but we don't tend to think of them the same way.

And as I look around the room and realize the backgrounds of the Commissioners, I'm impressed with how much I'm having to learn, but I also realize that except for Sara, I don't think that any of you have had to plumb the depths of dental is different. Sara actually began her career --

COMMISSIONER ROSENBAUM: [Off microphone.] Doing dental. It was my first State Medicaid lawsuit. My first State Medicaid lawsuit was over dental care in Maine.

[Laughter.]

UNIDENTIFIED SPEAKER: Well, you should have done better.

[Laughter.]

COMMISSIONER EDELSTEIN: She did well at the time.

So I wanted to share with the Commissioners a couple of just kind of fundamental background differences that make dental different that we have to keep in consideration as we take up this issue, including the dimension of the issue in terms of dollars.

Dentistry is a $100 billion industry, but only seven percent

of it is -- only seven percent of dental expenditures in the U.S. are governmental expenditures. How does that compare with the medical side? What is the percent of medical? Half? Okay.

VICE CHAIR SUNDWALL: [Off microphone.] Well, that counts as a tax credit that you give businesses to --

COMMISSIONER EDELSTEIN: Okay. And within Medicaid itself, dental for kids is required and dental for adults is not, which reflects another misconception that Congress has about whether or not the mouth is connected to the rest of the body, and Deamonte Driver became the unfortunate poster child to demonstrate that the mouth, in fact, is part of the body and that an infection that begins in a tooth can lead to overwhelming infection and death.

Only half of one percent of total Medicaid spending in the States -- maybe in some States as high as one percent -- goes to dental services. And if you look just at kids, it's about five percent of EPSDT expenditures, and that's compared to the private sector where it's about five times that, four to five times that. So people are often surprised that 20 to 25 percent of all child health expenditures in the U.S. go to dental care. That seems like a hugely disproportionate amount, but kids receive a whole lot more dental care than well children receive intensive medical care, and that's

why.

Congress has, as I mentioned, been confused about whether or not oral health is essential, and that's reflected in the fact that it's only through EPSDT that dental is a covered service. It's not because dental was specified as a service. It's not covered for adults. It's an optional service. And with the current economy, we're seeing States just continue to cut back on dental services for adults, including disabled children when they become adults who immediately lose their coverage.

The insurance model is extraordinarily different, and I don't think as MACPAC Commissioners we can deal with the insurance, or with Medicaid coverage without understanding the profound difference in the design of coverage. In the medical side, the entire insurance notion is based on the concept of insurance, shared risk. On the dental side, it's not even called insurance and properly not called insurance. It's called a Dental Prepayment Plan, and it's called a Dental Prepayment Plan because unlike a medical occurrence, which one of us has and the rest of us pay for, everyone is supposed to seek regular routine dental care, and so the way that it has been managed is by having a heavily copaid service with a strict cap.

Most of you know from your own experience that your dental

insurance doesn't go very far and that when you do utilize your services, you typically have high out-of-pocket expenses. This leads us to understand some of the comparison between low-income kids with commercial insurance and low-income kids with Medicaid insurance. Low-income kids with commercial insurance whose families have very high out-of-pocket expenses have the equivalent of having no insurance. They can't really utilize their commercial insurance because the copayments get in their way.

So what we have is we're often comparing kids without insurance, kids with Medicaid insurance and little access and kids with commercial insurance and little opportunity. So we have to be very careful when we compare, especially when we're looking at equal access issues, when we compare commercial kids, even low-income commercial kids with kids in Medicaid.

Similarly, or analogously, another major difference is the distribution of providers. There's a significantly lower number of providers available in general on the dental side than the medical side. One advantage that the dental side has is that it's about 80 percent generalists, 20 percent specialists, as opposed to the flip, so we don't have as much of a problem on the dental side as on the medical side in trying to find generalists and primary care providers.

The safety net is extremely small. Only about four percent of dentists are in the safety net.

And the availability of providers, or the unavailability of providers was really driven home by the new GAO report "One More Time." Let me just summarize a little bit from that report. Not only did the States say that there were very few providers, but in their Insure Kids Now, where the States list the providers, the error rate, in other words, the chance that a provider was actually accepting new patients was only 49 percent. So it was a 50-50 chance that a provider listed on the Insure Kids Now was actually accepting new patients.

So we inquired of the American Dental Association about the percentage of U.S. dentists who were active in Medicaid and we used the 30 percent of patients as the threshold because that's the high-tech standard for being able to access the incentives. And the answer was that there are 13,000 dentists in the U.S. who see 30 percent or more of their patient pool in Medicaid. That represents about eight percent of practicing dentists. So the availability is really as slim as it feels to parents who are trying to seek care.

Pediatric dentists see three times the percentage of Medicaid patients as do general dentists, and that makes sense because

so many more kids have coverage than do adults. But their rate of patients averages only 18 percent and about 40 percent of kids are in Medicaid. So you can see again this huge unavailability.

So taken together, I think we should be cautious every time we look at the dental issue and remember how different the dental environment is from the medical environment. We should also keep in mind that parental reports of their children's dental health are far, far rosier than reports of NHANES, and NHANES tends to understate the problem because it doesn't use radiographs and it uses only a visual examination and it uses a very stringent level. You have to have a really good-sized cavity to be counted as having a cavity.

I wanted to remind folks as to just how early and how severe this is. Eleven percent of two-year-olds have visible cavities. Twenty-one percent of three-year-olds, 34 percent of four-year-olds, and 44 percent of five-year-olds. So half of kids enter kindergarten already having disease, which is why Mary emphasized so much the importance of the early intervention.

The last thing I wanted to mention is that one of the things that's most baffling about dealing with the Medicaid population with their oral health is that we're dealing with a completely preventable disease, but as we look at new providers, the emphasis has been on

more people who can drill and fill teeth rather than systems that can really turn off the tap of new disease. The American Academy of Family Physicians, the American Academy of Pediatrics have both been really active in engaging medical care providers to help turn down the disease. But that's where we really have to focus, as well.

So I just wanted to turn your heads a little bit to think about how profoundly different because of the historical accident in the 1850s dental is from medical and how now Congress, even in ACA, was absolutely encouraging and accepting of dental coverage for kids but would not provide even the emergency relief of pain and infection in the essential benefits package for adults. So this idea that dental doesn't matter or that it's optional, it was optional in CHIP the first time around. The second time around, advocates were able to secure it as a mandate. It really is a different animal and we have to be very careful in our MACPAC policies about extrapolating from what we know about medicine into dentistry.

CHAIR ROWLAND: And Medicare doesn't cover dental care.

COMMISSIONER EDELSTEIN: And Medicare does not cover dental at all.

CHAIR ROWLAND: Did you have a comment?

COMMISSIONER GRAY: Yes. At the -- first, I would say, as

well, two excellent presentations and I applaud Dr. McIntyre's efforts in Alabama. As she was talking, I became painfully aware of my accent.

[Laughter.]

COMMISSIONER GRAY: I'm married to a Southern girl.

In Detroit, and it's really reflective of Southeast Michigan and probably the entire State, there are no practicing pediatric dentists in the city, within the city limits, outside of our Children's Hospital. We subsidize, and we're not in the pediatric dentistry business, I don't think, technically. Children's hospitals across the country, however, do provide lots of pediatric dental care, particularly to kids with special health care needs, because there are so few other places that will take it on.

In our community alone, the Detroit Institute for Children, which is a multi-disciplinary agency that provides health care and other services to children with disabilities, had to stop delivering pediatric dental services 20 years ago. We took on their patient base at the Henry Ford Health System, which dwarfs the Children's Hospital, gave up pediatric dentistry ten years ago. We subsidize three or four pediatric dentists, 13 operatories, and the need is nowhere close to being met in our community.

And it would seem to me that this is at least one of those

areas -- you know, there's been lots of talk today about payment levels and access, but it would seem to me this is one of these areas where Alabama's experience and ours in the reverse would suggest that payment clearly makes a big difference in this area, clearly not the entire difference, but it makes a big difference.

If you look at the population of children with special health needs, it's even more problematic, not just because of the reimbursement, but also because of the training and the skill of the existing dentists that we have. Our dentists in a frantic effort to sort of try to ease their own personal burden began giving Saturday educational training sessions to general dentists to help them to become more comfortable with caring for children, and it may have helped a little bit, but not really sure.

Question about managed care dentistry. Alabama is all fee-for-service, and I don't think I read anything, Jenny, in your paper -- I can't remember -- about difference -- do we know what the difference in accessibility to service between the fee-for-service approach and managed care -- dental managed care?

DR. KENNEY: As opposed to managed care that's --

COMMISSIONER GRAY: Right, because in Michigan, as an example, we have -- we're entirely, with very few exceptions, managed

care, medical managed care, but the dentistry is pretty much fee-for-service still.

DR. KENNEY: So to my knowledge, there is no comprehensive assessment of that. There are some State-specific studies, and I actually have contributed to that literature, but it's very episodic. I don't think you can generalize from what's been done.

And one of the things noted in the GAO report was that when you zeroed in on the 416 data and looked at the ten States that are dental managed care provided services in Medicaid, the rates were lower. But that's not reflecting necessarily a causal relationship. It just suggests that more study is needed on this important topic. So I don't think we know the answer to that.

DR. McINTYRE: And I just want -- we did have what I call a single experiment. It was Bay Health in Mobile County, managed care. That was our one step out under managed care, and I'm going to tell you, the dental providers early on rebelled. We lost ground in Mobile from the very beginning as far as from the dental aspect, as far as with -- I don't know whether it was the payment from the managed care entity or what the issues were, but I think a lot of it was, as I had indicated earlier, the whole idea of receiving what they call a discounted reimbursement is really a problem when it comes down

to dental, because the reality is, is many of them charge 100 percent of whatever their charges up front -- well, not up front.

When you come out, you write a check even if you have insurance. And then they will, in some cases, submit that and you get whatever the insurance company pays. But the dentist gets his amount in full. And I know that happens. I do it. I have to write a check at the end of my visit even though I have Blue Cross-Blue Shield, and then I get the check for whatever amount Blue Cross-Blue Shield would have paid the provider, but he gets the whole amount. So if the visit was $98, he is going to get the $98 and I'm going to get the $33 or whatever it is that Blue Cross-Blue Shield pays. So that's the reality.

And when Burt said about being different, you know, we always talk about we -- one of the things we looked at is we always heard about the overhead fee was much higher for the dental providers. Well, in some rural medical practices, they're extremely high, as well. And so when we looked at that, we tried to say, well, you know, yes, overall it probably is when you put everything together, including urban and rural practices.

And that's why I said the economy being bad has helped us, because when we started with the drop and everything really went

downhill, the rates went back up because, guess what, they took more Medicaid children in because they couldn't get people in, because we put off services when it's stuff that we do not consider as being important, and that's the whole thing about perception, about how important is dental services.

And that was one thing I had intended to say. If you can do anything, one of the things that needs to be addressed from a national standpoint is, almost like the AHRQ campaigns, is you need to put something out that explains how important oral health care is to get people to understand that. And I think that will help to try to drive up utilization, okay.

CHAIR ROWLAND: Patty?

DR. GAYNOR: I have four recommendations that maybe we could think about. One is that -- two of them deal with the issue of missed appointments, which are big issues, I think, for dentists. I don't know why they're bigger for dentists than physicians, because a missed appointment -- right, it is the same, but one is -- one thing that helps that, I think, is co-location of services. We have dental clinics right with all our medical clinics and it actually, if you have an opening, you can move people around. It works pretty well.

And I would say one recommendation that we should think

about, and I don't know what the data we would need to gather to make it is, but that the new access points that are being paid for out of the $11 billion that are going to CHCs, that there be extra credits given to those new access points that either already have co-located dental services or for the co-location of dental services, because I think that there still is going to be a lot of provision of both physical health and dental health care within the traditional safety net. So that would be something I think we could think about.

The other is while managed care dental may not work very well, I think we should explore the terrain of adding oral health into the medical managed care cap rate for -- at least for children. It may be just as part of CHIP. Again, I think that if it were in the cap rate, there might be more co-location and the missed appointment issue might not be such a big issue --

COMMISSIONER GABOW: The third recommendation that I think we should explore maybe for both gentle and primary and specialty care is, is there a way to do a sliding scale loan repayment based on the percentage of Medicaid patients that you see? Because right now, the loan repayment should be in a HPSA, but that has a lot of restrictions. I mean, this has money attached to it, obviously, so that may not make it good.

But I think starting to think about, in other countries where people don't finish medical school or dental school with large loans, you have a different playing field. So maybe the way to think about these public programs is to broaden out how this would work if you're a participant.

And the fourth thing was from Dr. McIntyre's FMAP discussion. Somehow this morning when we talked about the payment issues, we didn't talk about the criticality of the FMAP and how that could implode the whole thing. So I think we'd better add that back to the morning discussion.

VICE CHAIR SUNDWALL: I just need to just quickly say number three is right on the money because HRSA is right now looking about redesigning how they designate underserved areas, so they're looking at outcomes or health indicators, not geography or population. So that would be very complementary to what they're doing right now.

CHAIR ROWLAND: I would interested actually in both Dr. McIntyre and Dr. Edelstein's opinion or thoughts on my perception, is it accurate or not, that one of our problems is that dental schools so limit the size of their classes or, perhaps better stated, there's not enough dental schools. But is that not part of the problem? Is it that there literally aren't enough dentists to meet the needs of

our nation, much less low-income families and children?

COMMISSIONER EDELSTEIN: There are dramatic increases in the numbers of both schools and slots going on at the moment. With a change in the direction of schools, many of these new schools are oriented and focused particularly on service as opposed to some of the more traditionally academic approaches to dental education.

COMMISSIONER CHECKETT: I don't understand what that means, focus on service.

COMMISSIONER EDELSTEIN: Lots of new schools that are designed and located in places where there's a terrific lack of service. Eastern Carolina, Maine.

COMMISSIONER HENNING: I was really happy to see the obstetrical or early intervention, and I'm assuming that was an educational program where you taught pregnant women on how important it was that their children get dental care.

DR. McINTYRE: And it's actually continued. We actually incorporated into -- we have care coordinators, care management, requirements within our maternity care program, and basically part of that care coordinator/care management requirement is at the fourth visit they have to address oral health issues with the mom.

And so, then we also incorporate it now. It was a single

thing and we're talking now about how to repeat it. We did mail-outs to all of the OB-GYNs that explained to them in a little kit information about what was important when it came down to oral health care.

Now, the issue about not covering adult dental services, I had to get around and really battle within, internally, with how can you talk about oral health care services with the mom when you don't cover adult dental care? And we said that look, we can talk about prevention, we can talk about the importance, and we can work with our partners, which for us are the community health centers that do provide those services.

And one of the things that we incorporated, even though we didn't cover dental -- we don't cover adult dental is what we did provide access. When people called in and they're adults that didn't know where to go for adult dental services, part of what we've done is we have a list of all of the health departments and the CACs that have dental coverage and we can tell them where the nearest location is that had obtained access.

Now, part of the discussion happened, should we be doing it? Yes, we should. Even if we don't provide reimbursement for it, we can help improve the access by letting people know where care is and putting that information where they can get it.

So that may be something that you also need to consider in the desperate times with the way the budget is. Is there still things that states can do to help address some of the access issues and problems like working with those resources that they do have.

I want to come right back to that missed appointment issue. I did have it down on my thing. It has to be addressed. One of the things that we run into is the whole issue of there's no reimbursement for missed appointments, no ability to bill for missed appointments. It became one of the primary issues that we dealt with when we were dealing with the initiative.

How we dealt with it is with care management. Identifying someone the provider dentist could call in order to try to get the patient in to keep them from missing the appointment, but being able to have some way to do something would really assist in that.

So even in the time that we've called we've gotten a no, you can't, it can't be billed for a missed appointment, and maybe even consider putting in some nominal reimbursement requirement, which I would probably be shot for saying.

But the reality is, is that we understand, unlike a physician office when an empty dental chair is there, physicians, we schedule three and four people in the same time slot. I'm just

going to tell you, knowing that there's going to be percentage that don't show.

When a dentist -- a dentist can't do that. He's talking about a chair, a specific spot. So you have to think about that in all of this mix about what the differences are.

CHAIR ROWLAND: I really want to thank Dr. McIntyre. We promised we'd get her out at five o'clock and I don't want her to miss her plane. But it has been extremely helpful to have you here today and we thank you for making the trip.

DR. McINTYRE: And if I don't catch this plane, I can't get home tonight. So that's the problem. I've really enjoyed it and I am available at any time if I need to do additional stuff. There's a lot more information out there and we continue to work to try to address this.

I'm going to say one last thing as I get ready to get up. Dental home, dental home. We're trying to push it through as far as trying to get it done. Even if it's just for that early population, because the issue is, is do we have adequate dental provider numbers to do that. My thing is, start with a segment of the population and require dental home assignment, that segment, and then work to get the access in order to make sure that you can move forward.

So I'm trying to push this as our next strategy to try to move us along, and what we're trying to figure out is, where do we get the reimbursement for that care management fee, because like you say, what we do with that is we need the providers to reach out and get them in to help. That's what we do with the PCCM model for the medical care providers, and we need to try to do the same thing to get them assigned to a dental home so that they know where to go for care. Thank you.

CHAIR ROWLAND: Thank you very much and thank you, Jenny. I think this is clearly an area that we know we will be pursuing. I think this has been a great start for our discussion. Now I'd welcome anyone from the public who has a comment they'd like to make to us before we close.

PUBLIC COMMENT

[No response]

CHAIR ROWLAND: Then we will adjourn for today and resume tomorrow morning bright and early at 8:30. For the Commission members, 1 Washington Circle at 6:30.

[Whereupon, at 5:05 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, December 10, 2010.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

New Hampshire I & II
Renaissance Washington, DC Dupont Circle Hotel
1143 New Hampshire Avenue, N.W.
Washington, D.C. 20037

Friday, December 10, 2010
8:46 a.m.

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

LU ZAWISTOWICH, ScD, Executive Director

P R O C E E D I N G S [8:46 a.m.]

CHAIR ROWLAND: Good morning. Good morning and welcome to the continuation of this meeting of the Medicaid and CHIP Payment and Access Commission. We had a full and productive day yesterday and are ready to engage in an equally full and productive day today, and we are pleased to begin this session to look at some of the challenges in measuring access to care. There are issues of definition, and there are issues of survey data and what it can tell us. Yesterday we focused some on program data. Today we'd like to move to look at some of the advantages and problems of trying to answer the questions that we know this Commission will deal with, with regard to the survey data on access.

So, Chris, are you going to kick it off? Thank you.

MEASURING ACCESS TO CARE: DEFINITIONS AND SURVEY DATA

OVERVIEW

MR. PETERSON: All right. My name's Chris Peterson, and the most important thing to note on this slide is the date, December 10th, realizing how close we are to March.

[Laughter.]

MR. PETERSON: And it is for this reason that we want to get your buy-in and discussion on a definition of access, which came

up yesterday. It has come up before. So now is the moment. And what we're proposing is to use the IOM definition, which has been kicking around for more than 15 years. And then the issue is if that's the definition we use, how do we operationalize that? What are some of the proposed measures to get where we want to get in March? And then Mike O'Grady from NORC will discuss three options for producing survey estimates from all 50 states.

As I was doing the dry run with my wife last night, she said, "So this is a survey of the 50 states?" So let me be clear. This is talking about household surveys, so these are surveys of individuals that we're talking about, trying to get estimates of Medicaid/CHIP access for each state so that in every state we know what access will be.

So the three options he's going to lay out is to create a new survey, a Medicaid/CHIP version of the MCBS, and then to look at the existing surveys that are already out there, the federal surveys, because they are in two buckets. One is that there are surveys that produce estimates for all 50 states, but they don't have access measures. Then you have the ones that have access measures, but they don't produce estimates for all 50 states. So what is the best way to get at that? Do we add the access measures to those that

provide the 50-state estimates? Or do we beef up those other surveys so they can provide the 50-state estimates?

So the IOM definition of access from the Institute of Medicine report is "the timely use of personal health services to achieve the best possible health outcomes," or in my layman's language, I say it is getting the health care you need when you need it. And the key issue here is about timeliness; it's about when you access that care.

But the issue is how do you operationalize that definition. There are the words on the screen and on your page, but how do we actually apply that? And you can see that there could be some overlaps with other issues.

For example, when people go to get care in an emergency room rather than in a doctor's office, that could be an access problem. But it is also potentially a quality problem. So there are overlaps that we are concerned about. But there are other parts of quality that we want to probably focus on separately. For example, a person goes to a doctor or some other provider, and they are prescribed a certain drug, and one could say, well, actually another drug would have been better in this case. Well, questions about most effective treatment are not what we want to discuss in access, and the reason

I raise this is because a lot of times access can become a very big bucket into which you throw everything. And we're proposing in operationalizing this that we not do that.

In addition, when you look at coverage, usually in the health policy literature when people say, "Do you have access?" the first question that they will ask is: What is your coverage? Do you have coverage? And that's a great question when you look at eligible but not enrolled folks. But I think for our purposes, I propose in the way that we operationalize access is in a very focused way, for a couple reasons. One is that MACPAC is charged to separately review these other issues. They're very important issues. Quality, coverage, enrollment and retention policies -- these are things that certainly affect access, but they are not access per se in the way that we would operationalize this.

In addition, the Medicaid statute tends to define access very narrowly, so it isn't about, for example, making sure that all eligible individuals are enrolled. That's not the definition of access in the statute. The definition of access in the statute is: Given that you have Medicaid, are you able to get the care that you need equivalently to what the general population gets in an area?

So potential access measures currently available for MACPAC

analyses, I've put them into three buckets:

Structural measures of specific resources. So do you have a usual source of care? What is your usual source of care? Is it a doctor? Is it an emergency department? So that is one set.

Another set are assessments by enrollees. Do you have unmet need for medical care due to the cost? Does your doctor listen to you carefully? Does he spend enough time with you? Is it easy for you to get care, to get tests, to see a specialist? Those kinds of questions.

Then the last bucket are the utilization measures. So given the fact that you said you have a usual source of care, were you actually able to get care? Did you have a visit to a doctor or some other office-based health professional? Did you have a visit to a dentist?

And so we want to talk about options to improve Medicaid/CHIP access measurement. In our last meeting, Sharon Long had talked about the fact that nationally access to care in Medicaid is as good as private coverage on many dimensions; however, some gaps remain. And the point is that gaps will vary by state. We know this. We know that state programs vary substantially in what they cover and various approaches that ensure access. Yet we lack 50 state

Medicaid/CHIP access measures from the federal surveys, and so that's what Mike is going to talk about. He was the Assistant Secretary for Planning and Evaluation a few years ago and worked on some of these survey issues and tried to improve their quality and made sure that the folks from the Census Bureau who had their surveys were talking to the folks at HHS. And so he is well versed in these kinds of issues.

IMPROVING ACCESS MEASUREMENT IN SURVEYS

DR. O'GRADY: Thank you. Yes, good morning. I'm Mike O'Grady from the National Opinion Research Center. I'd like to talk to you and give you some options and talk about some of this stuff.

One of the aspects of this that often we run into trouble, or at least policymakers run into trouble in this area is that they tend to think -- I mean, most of us deal in health policy. There's also this aspect of data policy that will come into this, and you'll start to see that how you organize your data, what kind of data, how timely it is, that there's a number of trade-offs that you're going to have here as you think about recommendations you'd like to make.

First slide, please.

So in terms of when you consider -- and I have to point out to you also that when you see these major programs that go on, data collection that goes on, there's a little bit of an industry

capture that can often happen by the research community, that it becomes, you know, the generation of dissertations and people getting tenure rather than answering the questions of policymakers. And so it's important as you think about what your role is going to be in here that you not lose track of what we're really trying to do here, which is to inform policy for the most part.

So what are the real key questions you want to track, both over time and over location? How do we think the system will change? And will you be in a position where you can actually capture some of that change? State level estimates is certainly an important priority. Chris has mentioned it already before. Do you want to move, as this field has moved more and more in recent years, towards being able to use surveys as simply one component that you can either statistically or administratively link to people's claims files and to their administrative records like eligibility files and things like that. And so you won't be able to do everything, and so you kind of need to think through these priorities. What is top of the list that you really want to do here when you move into data policy?

So can you build from your current surveys or do you need to build your own? That's sort of always one of the questions that comes into these areas, and have you got enough of a core that someone

else has already paid for, someone else already has gone through all the hassles of the sample and all these sort of things, which are very complicated? Or do you really have to start from scratch?

Unfortunately, like everything else, it comes down to money in terms of what is the financial commitment, what is it ongoing. We've seen a number of examples in the past where surveys had great potential, and then they didn't get fully funded, and the sample size went from 100,000 to 50,000 to 20,000, you know, and then they're gone.

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So you need to think about what is sustainable over time given the policy questions that you're trying to answer.

So there's a number of things, potential elements here that I want to run through kind of quickly for you in terms of when you're specifically thinking about Medicaid and CHIP access, so certainly state and national levels. At what point do you need this? If you can't get every state, what is okay? What are your trade-offs in terms of, Is it all right for the policy questions you're trying to answer that you collapse two years of data, or even three? How do you want to do those sorts of things?

Clearly, if you want to go to big surveys that are able

to give you annual -- you know, right down to Delaware and Rhode Island, they're more expensive. You know, they are more complicated to be able to draw samples and things like that in those sorts of states.

Health insurance coverage estimates. SCHIP and Medicaid, of course you want that, but how important is it in terms of when you wrestle with it to know other things that are going on? What kind of employer coverage? How does your population compare to the people who are getting coverage through an employer? The exchanges will be coming online in a couple of years. So it's important to at least keep that in mind as you move forward so you don't set up something that makes perfect sense for today but will be awkward and, unfortunately, possibly obsolescent five years from now when all of a sudden exchanges are up and running.

Certainly Medicare and the uninsured, we still, after reform, will still have not an insignificant number of people without insurance. And so how do you want to kind of -- how much of that do you feel you need to capture and have good ongoing data on as you move forward?

Access to care measures. Certainly prevention is very important, utilization, usual place of care. Some of these things that are going to be major operational things you're not going to

want to fly blind on. You're going to want the best data you can have.

And income, poverty, especially as we think of some of the work that has been done on social determinants of health. What kind of a context do you want besides -- you know, you can look at claims data and get a feel and a lot of detail, but you have no idea of the income of the people. You have no idea of how poverty is coming in. In some of these issues, it can be very tough, things like citizenship. As you can imagine, somebody from the federal government and starts asking you questions about, you know, are you here legally or illegally or what is your status? Your sample verification and what-not is pretty poor. Nobody comes up and says, "Hello, I'm an illegal" -- you know, "I'm not here legally."

So do you want to think about that? And what do you want to do with it? Do you want language spoken at home or some of these more indirect measures that can still get to some of the things you're concerned about because you're not immigration enforcement, you're health policy.

Next slide, please.

Okay. One possible model that's done out there is what Medicare has done. So the Medicare Current Beneficiary Survey is a major survey that's done every year, and it's done a little differently

than the other surveys I'm going to talk to you about. Normally in the federal government, there are statistical agencies that handle -- you know, when you think of the Census Bureau, for the Commerce Department and really for the nation in many ways, the Census Bureau does an awful lot of the survey work. HHS is an exception to that where you will see some statistical agencies, but you will see surveys like this that are actually in effect run by the administrator of CMS. He kind of has his own survey here. And that means that it's much more closely tied to the policy decisions that they're facing and what goes on in that agency. Other things you'll see are run more by statistical -- like I say, the statisticians have more control over it.

This is a continuous multi-year survey. It's about 16,000 people a year, and given it's Medicare and you basically have one benefit package for 80 percent of the people, that's great. That works pretty well for them. It does have a number of goals that they have here in terms of determining expenditures. They're mostly looking for those interactions. Medicare has major problems with sort of Medigap and secondary insurers, so this is where they collect their data that you're not going to get out of a claims file; what types of health insurance coverage they're doing in these other sources

of care. So it is very focused on their program and the ins and outs of what they need to do.

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So timing. Other things having to do with data collection -- and the data collection people get beat up about this, but the data comes in and is often quite poor and things, and they have to go back. So there tends to be these time lags. They normally can get data out of this survey one to two years after the survey -- you know, they're ready to start releasing results. It's in good enough shape. Start-up for a new survey would add even more to that. If you're starting from scratch, it's probably going to take you at least two to three more years. On top of that, you've got to think about how you're going to build these systems, how you're going to draw samples. There's nothing worse than spending all this money and spending all this time and find you really can't say very much. You know, the sample was done wrong, or it wasn't -- you know, you undersampled here when you needed to.

This one runs around $15 million a year. If you were to try think about kind of what a Medicaid/CHIP version of that would look like, you know when you move to the state representative samples, you're talking about -- you know, you're not going to be able to get

away with interviewing 16,000 people and being able to say you really have got anything. You know, if you've got four people in Delaware, I'm not publishing results on that or deciding policy based on that. That's just not enough. So it's going to be very expensive, or at least -- but we're saying if you need four times the sample -- and we're doing, clearly, very back-of-the-envelope at this point. But you're talking about three times probably as much of an expense of what they're doing because you really would want to sample people in every state, not, you know, 100 people in Wyoming and say that covers the Rocky Mountain States. You really want somebody in Montana; you really want them in all these different states.

So federal surveys that do 50-state estimates -- so that's sort of one option. Build your own, think about how you do that. The next two options I'm going to talk about are how you would build on what's already there so you don't have to start from scratch and you don't have to -- you know, somebody is already spending money to do this.

The two surveys here that are the best -- one of the things to kind of conceptually keep in mind here is that when you can't have everything, the way the people have gone before you have done it, they either have surveys that have very large sample sizes, and so

they're great to be able to say Delaware versus Rhode Island, et cetera, et cetera. But they don't have a lot of questions, certainly not in health, because the surveys we're going to talk about now, there's also housing, there's education, there's income. They're done by the Census Bureau. They're done really the whole range. So you might get ten questions on health, and if you're lucky, they're not the last ten questions so the person is already exhausted and just wants you to leave their house. But, you know, you're not -- so you're going to see breadth but not depth. And then as we talk -- in the next group we'll talk about are much -- they're HHS, they're run by health teams, they really know about health, but they're not going to have, like in this case, 3 million households.

The first survey I'd like to talk about briefly is called the American Community Survey. It's brand new. It's replacing what we used to think of as the long form from the Census Bureau. So it has much more than anything else that we've seen before. You'll see as I talk about these 3 million is -- that's kind of the gold standard. Nobody else gets up to 3 million people. And as you can imagine, it's big and expensive. It does replace -- but it does allow you to -- it's trying to address -- mostly for state and local governments who are trying to wrestle with financing and access and a number of

different issues and allows them to have that detail.

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Okay. So if you were thinking about an option, how would you add to this? You need to know both time and money, what you're talking about. If you're going to add new items -- and we sort of took a generic, you know, that you weren't going to add a hundred new items because, candidly, they won't let you; you would kill their survey. But three to five years to add new items. A lot of these things, if you're going out to 3 million people, you do a lot of pre-testing. You make sure the questions are understood. You do them in Spanish. You make sure as you go from one state to another if, you know, you're in California, you call it Medi-Cal. You know, you really fine-tune these things, and it takes a long time to do them.

Two to three million to add new items, again, assuming a reasonable number of new items. Comparisons to other forms of health insurance. Like I say, this is the sort of stuff that will give you a broad view from a lot of people on what goes on. But it's not going to give you a lot of depth. It does allow you to get to institutionalized populations who are traditionally in the other surveys very, very difficult to get much information on.

These surveys have done a fine job, but they have had a

problem, a bit of a chronic problem of not the most precise measurements of Medicaid and CHIP in the past.

The second survey -- oh, I'm sorry, Chris. I'm flipping between columns here.

Another one is the Current Population Survey. This one, whether you're aware of it, you see all the time. This is when they tell you the annual poverty rate and things like that. This is the Census' main annual survey that they do. It's a smaller group of people. It would not cost as much to add to because you're talking, I believe, 60,000 households, not 3 million, that sort of a range. But, again, to keep in mind here, the Census Bureau has started to move in -- maybe 10, 15, maybe even 20 years ago, they moved into health because it became clear to them if they were going to measure income that an important component of income in total compensation was health insurance. They sort of came to this lately, you know, and kind of backed into it because of their interest in income. So it's going to have a couple of warts on it, if you want to think of it that way.

Okay. So next slide, please.

Now, as I said, there's a couple other surveys that are good national surveys. They're not great in terms of being able to

state-level estimates. They've worked very hard on both these surveys -- the National Health Interview Survey and the Medical Expenditure Panel Survey -- to be able to squeeze state estimates out of them as best they can and improve their -- and they're doing a good job, but I don't want to kid you to think that these are major things that are going to be 50-state estimates. They need to collapse ten years to give you Delaware and things like that. So some problems there.

They're both run out of HHS, the National Center for Health Statistics, which is part of CDC, so there is a little bit of a public health kind of angle to this. Thirty-five thousand households containing 87,000 people, roughly, every year. It is a major tracking of public health characteristics, but not much financing. So when we looked at this to see would it be helpful in terms of thinking about a Medicare drug benefit, we saw lots of stuff on, you know, did the diabetics take their meds. We didn't see what the diabetics paid for their meds and, therefore -- you know, in some of that, it got us kind of halfway there, but not all the way in some of those analyses for implementation.

Now, the MEPS is run out of AHRQ, again, an HHS survey. The one thing to keep in mind with these, these are sort of sister

surveys. So when they go forward and they do 12,000 households, those are 12 -- that's a subset of the 35,000 that the CDC people have done. So that statistically allows them a lot of things. Even though they have really good, deep questioning, there are 12,000. They know that if they need to project up, they're already like part of the same sample. And statistically, without getting into it, that makes your life much, much easier, that you've drawn from the same sample.

So, anyway, option three, what if you wanted to build on these? Like I say, they're smaller surveys in terms of the number of people they went on, but they're much more extensive in terms of sort of the health questioning and the health data, related data that you get here. And keep in mind, on any of these we're talking total sample size. We're not talking how many Medicaid and CHIP people they've talked to. So you know that's a sub-sample of their base sample that's going on here.

So if you wanted to do this, new measures, like I say, these are smaller surveys. They're a little bit more flexible. These are surveys, both of them, that have problems where over the years they've not been as fully funded. So if you come forward and you say we'd like to add questions and we've got some money, I think both agencies would probably not hang up on you. You know, they would both be

interested in talking about it. Three to five million to get the state-level estimates probably from the National Health Interview Survey. This is, again, our back-of-the-envelope estimates at this point, and there will be further analysis to nail those down a little better for you. And then you're in a situation if you wanted to go with the very more extensive MEPS survey, it would be three to seven million.

Now, the thing you have to know because of the advantage I talked about a second ago about how these things are linked together, if you wanted to do the MEPS survey, that would probably be additive, the three to five million, because you need that sample size built up to give you state-level estimates on the main sample, and then the five to seven to then do the extra questions and make sure you got to those sort of questions. So certainly better health measures, currently small sample sizes is the main problem you're working on here, and they're expanding. They're trying to expand as long as funding is available.

Okay. Final thoughts. You know, you can't get everything here. It would be nice. But for the most part, policymakers, when they're looking at where they're going to spend the next $2 billion or something, are not going to spend it on surveys. They're going

to send it to NIH for the next breakthrough or whatever. So you're probably not going to get that kind of support that you would like to be able to do everything. So you need to think through, as you're kind of contemplating this, are state-level estimates at this point really the grail? Is it really what you want? Is it the top priority? Links to claims administrative records, again, the potential is very powerful. The early data on being able to do that is very strong. Or, you know, is there something else you want to really kind of put to the top of the list?

Can you be doing this by building on these current survey products? Certainly to start from scratch is a difficult task. It would be nice if you can figure that you can get where your priorities are from these things. It will make your life a little bit easier. And financing. It is a single funder? Is it that sort of situation like I described with the Current Beneficiary Survey for Medicare where really it is within -- you know, it's right down the hall from the administrator, and if the administrator says we're heading into -- I need to know about long-term care, you know, they add questions on long-term care. There's none of this, you know, talking it over with three different agencies and they move forward. But it does mean how do you sort of share that, and often on these surveys there are

multiple agencies that fund these surveys in order to add what they need to.

So a number of things are certainly CMS, ASPE, that I used to run, or the states. For the most part, the states have not -- I mean, the states are certainly always underfunded and always in a tough spot. But there's a lot of data here that there's -- you need to have that federalism kind of discussion about how much is it for federal taxpayers to purchase data that is mostly for state applications. You can come to whatever conclusion, but you probably have to not -- you'd have to think that one through.

Thank you.

MR. PETERSON: Thanks, Mike.

CHAIR ROWLAND: Thank you. Let me ask you one question, Mike. Could you talk a little bit about how long it takes or what the time frame is between when they're in the field on these surveys and when the data could be released?

DR. O'GRADY: Yes. It's -- I think you should probably keep in the back of your mind a couple years as a ballpark. So what happens here is -- and it depends. And it will depend to a certain degree on what you really want. So if you really want some of these links to administrative records, you are a little bit held hostage by the

quality and timeliness of the administrative files.

So if you are just saying we are going to run a survey, maybe somebody else in the future will link it but we are not really going to worry about that, I would think probably there is a year to 18 months just to sort of do the pre-tests and get it all and make sure you have got that right -- and all these are Federal surveys, so you're talking an OMB review process, which is not quick, probably six to nine months. But again, that will depend on how you do this. If this becomes a chief priority of the Administrator of CMS, that six- to nine-month review can be made a two- to three-month review. I mean, they still have to do due diligence.

And so then you want the pre-testing, because all kinds of times they come up with surveys that they think they're asking the question the right way to elicit the real information and that's not the way, you know, the public views it when you get out there.

So I'm saying, start to finish, you're probably talking three to four years.

MR. PETERSON: And let's go back to the beginning so we can work through each of these things and then we'll come back to Mike's parts. So to start back with the definition of access and the proposal, just to use that IOM definition that's been kicking around

for years, if there's any issues with that.

CHAIR ROWLAND: Judy, and then Trish.

COMMISSIONER MOORE: I think the only problem with the IOM access definition is there's been so much attention in the last few years to enrollment and eligibility efforts that we just need to keep -- if this is the correct definition, and I think it makes sense for us to use it, we need to keep defining it for people. We need to keep explaining that we're not talking about getting a card, that that's not our definition of access in this case, even though it's incredibly important and so on and so forth.

MR. PETERSON: Yes, and I'll just reemphasize that in the MACPAC statute, that is a separate thing that we are to look at --

COMMISSIONER MOORE: Yes.

MR. PETERSON: -- those enrollment retention processes. So that is definitely going to be a focus.

COMMISSIONER MOORE: That's another part of our work that goes on elsewhere.

CHAIR ROWLAND: Trish?

COMMISSIONER RILEY: This is my favorite issue, and I'm a naysayer without a good suggestion, so I recognize it's a bad place to be, but I think the IOM definition may be problematic because it's

15 years old and the reality is we increasingly understand that more is not better, that we have a highly inefficient health care system, and the more we compare access measures that just suggest more, more, more is better, better, better, the more we feed into the notion of inappropriate and over-utilization. And I'm very worried about continuing that, especially with the focus on this -- the newness of our operation, the implicit assumption in our title that access is solved by more payment, which I think we've got to address very directly, worries me a lot.

So I don't want to know general access because I don't think it really tells us anything because of the inefficiency in the health care system and the inappropriateness of so much care that goes on, all the spending. What I want to know is access to things that have evidence, where we clearly know that there's good evidence that tells us that everybody needs a medical home or that everybody needs an XYZ. I'm not familiar enough with that data to know what those things would be, but I think there's far more value added, that the card gets people access to things that matter, that are efficient and effective delivery of care, and I think that's really a struggle and it's really moving us in a different direction. But I'm really nervous about this notion that more is better.

MR. PETERSON: And I think that that definition of access doesn't necessarily lead you there, that there is the part of the definition that says, this is the care that's required to get you the best possible outcomes, that it is the care that you need. And so there are overlaps --

COMMISSIONER RILEY: [Off microphone.] The measure on the slide, the EG in the slide says something about the outcome measure is did they get the service.

MR. PETERSON: Right. Right. And so this is going to --

COMMISSIONER RILEY: And it might be inappropriate service. It might be too much service. It might be inadequate service. I mean, I don't know what --

MR. PETERSON: No, so again it's --

COMMISSIONER RILEY: -- how we really define access.

MR. PETERSON: No. So again, it's about trying to get what the recommended services are, and I think that's probably to your point, is it's not just getting, you know, all the visits that one could possibly want. It's based on a standard and based on the evidence. So I think we're on the same page and I think that there is enough flexibility in that language to get you there.

VICE CHAIR SUNDWALL: Could I just make a comment on that?

I want to kind of support our adopting the IOM because it's so on point. It is so succinct. It's just a few words. And I think because it says the health care you need when you need it, not what you want -- we know the problem, Trish, is people want what they want when they want it and actually --

MR. PETERSON: Actually, that was my interpretation of the definition, so if you like that better, that's fine. I like it better, but, you know --

[Laughter.]

VICE CHAIR SUNDWALL: We have to leave it to wiser minds to determine the need, but I think getting it when you need it, and I think it's very succinct, but let me just give you an example.

In Utah, we have about 48 safety net clinics around the State. Much of the care is provided for people with no insurance at all or they're under-insured, and so you can't -- like we have heard, coverage does not equal access. It's a very big, important part of it. But we did a survey that showed that we in one calendar year did a quarter-of-a-million visits in just our safety net clinics. Most of those would be on public assistance, but a significant minority had no insurance. Who knows how much money we saved by not going to emergency rooms or what have you.

But I think this is succinct and I think it's usable.

CHAIR ROWLAND: Okay. First, Steve.

COMMISSIONER WALDREN: I mean, first, I agree with Trish. I think that access is critical for these patients, but I think it's also critical for us kind of out of the box to make sure that we truly understand what access is.

I guess I don't have a problem with us getting kind of a more concrete definition, a working definition, but I think we also have to have kind of a broader discussion in our report talking about access, because one of the things that I -- you know, 15 years ago we talked so much and it says, personal health services, and it was really about the individual. And what we've really started to do in health care is started thinking about how do I take care of a group of patients? How do I take care of a population and how do I drive that forward?

And I think when we start talking about Medicaid and CHIP, we talk about not only the individual access, but the population that that particular State serves. What type of access do they have? And I think we're going to start getting into issues of, you know, do we pay for dental, like we talked about, or do we pay for exercise programs for kids for obesity. There's evidence in both those places,

but there's also kind of that value thing, saying these are the amount of money that we have in the State to work with.

So I'd be okay with us working on this as kind of our "working definition," and I'm putting quotes for the transcript, but I think we also need a larger definition to really tease out a lot of these issues with quality and other things like that.

MR. PETERSON: And I think that's really the point of operationalizing the definition. So it's one thing to have those words as they are, but then it's a question of what is our focus going to be, and it's kind of like the Constitution or the Bible. There are the words. What's your interpretation? And so I think there is -- in this conversation and in the report, we will flesh all of that out and get to a place where everybody's comfortable at, I believe, with how we're describing access, how we're defining it, how we're measuring it, and then moving forward, where we need to tweak things, where the emphasis needs to be to make that measure better -- those measures better.

CHAIR ROWLAND: Okay. Patty?

COMMISSIONER GABOW: I guess one thing that we may want to think about is what does best possible health outcome mean? Does that mean having access to every available therapeutic intervention,

independent of cost and independent of the period of efficacy? So, for example, if it were a drug for cancer that cost $100,000 a year and extended life for two weeks, on average, some might interpret that having access to that in the bin of the best possible health outcome, whereas others might say that's not really thinking about the appropriate balance between getting the most health for the most people versus the most health for a few people, sort of two different ethical approaches to the question of "best."

So I don't know that we have a better definition, but I think not thinking about what that means or at least articulating what we mean by it would not be --

MR. PETERSON: And that's what I was trying to raise in terms of the overlaps. I don't think there are -- I don't think the lines are necessarily super clear. There will be some spillover. And I think as we go through our processes, we will decide where we are going to define these things.

I would tend to put the question that you've raised more on the quality side, and I say that because, again, MACPAC is charged to separately look at those issues, and so quality then becomes a lever that affects access. And so you can frame access in terms of how you've talked about the quality stuff. But there's going to be

flexibility. That's the point. And we will work on this as we move forward.

CHAIR ROWLAND: Do you want to come --

COMMISSIONER RILEY: Can I just follow up on Patty for a second, because I --

CHAIR ROWLAND: You can follow up, and then we've got a whole list. Okay.

COMMISSIONER RILEY: I'm sorry.

CHAIR ROWLAND: No --

COMMISSIONER RILEY: I think maybe in the narrative, what we need to do is talk about the trade-offs and the definition of access, because is it access for the program and all those eligibles or access for an individual, and to Patty's point, it's different. You could provide maximum access to everything to some subset and leave everybody else uncovered.

CHAIR ROWLAND: But clearly, to pick up on Steve's point, we have to look at personal versus population.

Sara?

COMMISSIONER ROSENBAUM: Yes. The second part of the clause is clearly the troubling part of the clause here, and I'm just wondering, is it possible -- not being familiar with the literature,

I don't know what definitions the staff considered and discarded. So I know what you want to use, but I don't know if there's a definition that literally stops at the end of the first part of the clause, you know, because it is -- I think of access as can you get to care. Can you get to care, not whether the care that you get to is necessarily the most appropriate or of good quality. And I just wonder whether there's an option for us that doesn't blur the lines quite as much as this one does.

MR. PETERSON: Well, I think that, to be honest, it has been kind of just the used definition that I've seen. So it's, again, an issue of interpretation. How do you make the best use of it? And so it gets back to the point of if a person is going to an emergency room instead of a doctor's office, is that good access? One could contend no. And so I think we're going to have to define where the line ends. And again, it's going to be -- it's not going to be necessarily clear, but --

COMMISSIONER ROSENBAUM: Yes, but the characteristics of where one gets the service is yet to me a third bin, which I want to come back to, and that is one of the most crucial things we're going to have to talk about in our access reports, is that even though -- and I wasn't here for Sharon Long's presentation, I guess it was

the last meeting -- even where gross measures look the same, children get as much well child exams if they're on Medicaid as if they're privately insured, the fact is the characteristics of the places where they're getting those services may be very different, and sometimes the characteristics may be bad. I mean, you're not getting a well child exam in the emergency department. Sometimes the characteristics are very good. If you're getting your service at a very comprehensive site that can do a range of things, that's maybe something that we want to promote in terms of access. But characteristics, quality, clinical quality of the care, and access to me are three very different concepts.

EXECUTIVE DIRECTOR ZAWISTOWICH: And what we can do as we develop the definition of access and we develop this part of the chapter, we can take all of these issues into account as caveats, concerns about the definition, and we can also set forth another definition for your consideration.

CHAIR ROWLAND: Burt?

COMMISSIONER EDELSTEIN: I'd like to raise for our consideration a serious concern about the first clause, the first part of the clause, because I think it conflates access with utilization. It reads, "the timely use of personal health services,"

which suggests that not only are the doors open to patients seeking care, but that they walk through those doors and obtain the care. And I think there's a fundamental difference between access and utilization which is masked in the first part of this clause and critical for us as a Commission to determine which we're talking about.

Are we talking about whether or not care is available, or are we talking about whether or not people utilize the care once it is available? And to me, the access, as we try to narrow it, is more about whether or not the programs that we're attending to, Medicaid and CHIP, provide for the accessibility to care, because there's a whole host of separate issues around the beneficiaries' utilization, choice to utilize or not utilize services.

So both because of that, and then the second half, which we've already attended to, this makes a handy conceptual definition, but I'm really curious about how, as a Commission and as a staff, we would operationalize it.

MR. PETERSON: So I would just say that to your point, in the literature, there's potential access, which is the usual source of care measures. Then there's realized access, and that really is utilization. So the literature does use the idea of actual utilization.

COMMISSIONER EDELSTEIN: And which is the concern for the Commission, is my real question.

CHAIR ROWLAND: Both.

COMMISSIONER EDELSTEIN: Is it both?

VICE CHAIR SUNDWALL: [Off microphone.] It's statute.

COMMISSIONER EDELSTEIN: How by law?

VICE CHAIR SUNDWALL: [Off microphone.] As I understand our statute, we must look at access and utilization. We're not just about -- you know, read our charge and I think it covers both pretty clearly.

COMMISSIONER EDELSTEIN: In that case, I think it would be a handy rubric for us in all of our work to distinguish when we're talking about access and when we're talking about utilization.

CHAIR ROWLAND: Andy?

COMMISSIONER COHEN: So really, I just sort of had a factual question. What does -- I mean, I have a sense of what a personal health service is, but is there -- is that sort of -- is it a term of art, and what is not included in personal health service? I agree with much of what has been said here and I think we should really consider carefully -- I don't want to mess with the IOM, but --

[Laughter.]

COMMISSIONER COHEN: -- whether something 15 years old is exactly right. So I do feel strongly that we should at least consider that. But I don't even really understand in a strict way what personal health services means.

MR. PETERSON: I think it's just trying to cast out a wider net. For example, dental care, if there's a medical care. So it's trying to cast out a wider net. Maybe that's not appropriate. Maybe we need to rein it in and to provide you with --

COMMISSIONER COHEN: What does the "personal" part mean?

CHAIR ROWLAND: It usually means that it doesn't include medical education and building hospitals and other things when you look at --

COMMISSIONER COHEN: But that's in terms of, like --

CHAIR ROWLAND: -- spending.

COMMISSIONER COHEN: -- from the provider perspective. But from the person, the beneficiary or recipient's perspective, what does a personal health service as opposed to a --

CHAIR ROWLAND: A personal health service is probably much more related to the use of services by an individual as opposed to, say, a community-wide immunization effort.

COMMISSIONER ROSENBAUM: I think it's a modifier for

researchers and not a modifier for the patient. You know, it's like research talk for people who are trying to distinguish between broader expenditures. But I was thrown by it, as well. I don't think it's meant to distinguish among the kinds of health care you or I would go get as patients.

COMMISSIONER EDELSTEIN: The term is used in the National Health Expenditure compilations by CMS to capture the full set of health services.

COMMISSIONER ROSENBAUM: Exclusive of research.

COMMISSIONER COHEN: But it certainly doesn't exclude -- I'm just wondering if some of the things we value in health care are changing a little bit so that, for example, I don't know, group diabetes education classes, is that a personal health service?

COMMISSIONER EDELSTEIN: It is. It would be in this.

COMMISSIONER COHEN: Okay. Okay.

MR. PETERSON: I want to make sure we have enough time to discuss the things that Mike is here for, if it's all right, if we could move to the other part, unless there was a --

CHAIR ROWLAND: I think Robin had --

COMMISSIONER SMITH: I just had a quick comment.

MR. PETERSON: Okay.

COMMISSIONER SMITH: I think that maybe using this as a springboard to build a definition on. But I think we've been given such a huge mandate that it may behoove us to come up with our own definition. It'll be the MACPAC definition of what access is. That's what I'd like to see. I'm very simplistic.

MR. PETERSON: Okay. And then for the options that Mike O'Grady had raised in terms of Medicaid's version of the MCBS, which I also wanted to note -- he raised it briefly -- one of the trade-offs with that, as well, is that this kind of survey would be focused just on Medicaid-CHIP. So it would not enable you to do comparisons to other types of coverage and the access there. So that's another thing to keep in mind. So is there discussion on these options?

CHAIR ROWLAND: Mike, I wanted to ask one question. You know, obviously, the MCBS does contain information on the dual eligible population, which is going to be one of the focuses of our work as well as MedPAC. To what extent can you comment on how adequate the Medicaid part of the MCBS is for those dual eligibles?

DR. O'GRADY: You know, it's more the categorization of that this particular, you know, this subpopulation is duals versus -- so there is not -- unless you go the extra step and start linking to Medicaid files, which certainly can be done and is being done more

and more every day, that you are actually seeing much of that. Well, what was their Medicaid spending versus their Medicare spending and can you see those sort of patterns that might be fairly important to your deliberations.

So it's sort of -- one of the things that it gives you, though, that we often don't see when you simply look at administrative records or claims files is it gives you all those sort of demographic and other measures. So it's what you need to get started to do that, but it probably doesn't get you all the way there.

CHAIR ROWLAND: Nor does it allow State-specific estimates.

DR. O'GRADY: No. I would -- maybe California.

CHAIR ROWLAND: And Texas.

DR. O'GRADY: Yes, you know, that kind of thing.

CHAIR ROWLAND: Andy?

COMMISSIONER COHEN: Just also another specific question. Do any of the survey vehicles that you talk about -- can all of them be linked to administrative data or are there any limitations in terms of one survey or another --

DR. O'GRADY: Some of them, we haven't tried yet, so it is that idea of, you know, you sort of try some and you do a dry run

and you see. I have to tell you that in the linking, which I think Chris has had some more direct, you know, when you're linking and you can't do it -- I tend to think of linking two ways. One is administrative. I've got some sort of unique ID. You have to be very careful about privacy concerns. But I know this is you over here in this file and this is you over here, and that's sort of the strongest link, if you can actually do it.

We also have what's done is called statistical linking. So you can take a look at the population and you can kind of use survey data and you say, okay, I have these ten variables that I have survey on, you know, age, income, et cetera, et cetera, and I have these same ten variables in the claims file. And so I basically model and predict from one onto the other.

But if you're mostly focusing -- the example, and like I say, Chris can talk about it more, but if you're focusing mostly -- and you're sort of matching on race, ethnicity, and income, you may find you're not matching particularly well on urban, rural, or something, because you're kind of focusing on this is my priority, so I really want the numbers to line up right for these five variables.

And so it can be -- it's not as rigorous as if you actually go through the process, get your kind of clearances for the privacy

stuff, do all the things that they will ask you to do. Certainly, HHS has big privacy sort of firewalls to make sure nothing is revealable about the individual. And then you really know you're looking at this person's claims and this person's survey, which with the MCBS, that first option, it's all within CMS.

So their ability to do it is a very powerful -- so they get -- like to go back to the Medicare drug, we had a lot of trouble knowing, getting good data on Medicare drug spending by the Medicare beneficiaries. We had good data from both the claims on what their hospital and their doctor. So you could compare survey data to claims data and know what your under-reporting problem was when you said, how many times. So you could then look at their answers about drugs and say, yes, but they underreport, I think in that case, 17-point-whatever. And so you were inflating their survey answers, but you had a fairly good analytic reason to do that.

So that ability is just powerful in terms of if you can look at both their survey answers and their actual claims --

COMMISSIONER COHEN: And in theory, you could do it for all of them, but you've only actually tried it for --

DR. O'GRADY: There's about six or seven of the major surveys that have been linked, some of it Medicaid links, some of

it Medicare links, and how you do that. And, like I say, these two different ways. It's best if you can actually --

COMMISSIONER COHEN: Right.

DR. O'GRADY: But there's these other things that will allow you to do it, at least statistical projection.

CHAIR ROWLAND: Judy?

COMMISSIONER MOORE: This is really tough stuff, and it's also expensive stuff. But it's also kind of critical to the Commission and where we're going to go. In the long term, we've got to have more data than we've ever had before on the Medicaid program, and it's hard for me to know which -- I mean, there are pros and cons to all of these surveys and there are big financial implications. And I guess in the best of all worlds, what would you, Mike, or you, Chris, or the staff think would be what we need -- what is the optimum path for us to follow here?

I would say one more thing, and that is our discussion yesterday was of a little concern to me because I think that we need to put some more emphasis on the things that CMS is already doing and put some pressure on the States to report things in a more timely manner than they sometimes do and get further along on that score, too.

But back to the surveys and our task for today, I'd just like to know where you think we ought to be on this.

DR. O'GRADY: Sure. If it were me, I would take two tracks at this point. One is to have the conversation you need to have amongst yourself about what is our real priority. If there's only enough, it's not your funds direction, but if you're going to have that meeting, you're going to make these recommendations, you're going to take it to the Hill, you're going to take it to CMS or to HHS in general, you know, you're going to have to have a short list of what your ask is, and it can't be everything or it'll be dismissed immediately. So you have to kind of fight through that one.

At the same time, the second track I would take is I would flesh these out. I mean, this is -- we can give you sort of our back-of-the-envelope. But I would actually, as you start to figure out your priorities, then you can start to match up and say, well, you know, for one and two, really, this current beneficiary survey model seems to do the best for us, but we're not going to get three, four, and five. And therefore, you just have to make those decisions as it comes down to your recommendations. If you want to say both these are what we think are the -- to inform policy and to be smart about a program where you spend, what at this point, $300, $400 billion

a year, and to worry about a couple of million one way or the other for a survey is just penny wise and pound foolish. And so you're kind of moving yourself and keeping moving on the recommendations.

And it would be a great contribution if you could do this, because in this area, we certainly see that there is a big disconnect, especially when you have kind of the statisticians all sit over here, where policy makers use this data all the time and never really know that's what the CBO cost estimate is based on. So that when the appropriation comes up, they go, well, what do we need this for? And, therefore, this -- and as you can imagine, survey statisticians are not widely effective lobbyists for their own --

[Laughter.]

DR. O'GRADY: You know, it's just not their thing. So you see this sort of problem coming in.

So if you can weigh in and say, U.S. Congress, Secretary of HHS, if you really want the information you need to make smarter decisions than you're making right now, here's an investment you can make that will give you this, this, and this.

CHAIR ROWLAND: Mike, isn't one of our other big concerns to what extent we need State-specific data versus national data?

DR. O'GRADY: Right.

CHAIR ROWLAND: And if you do a national sample and you have an over-sample in some of the bigger States, is that a legitimate thing for us to be looking at or do we need to be able to do Maine as well as Texas and California? I think that's something for this Commission to deliberate on. Some things, we may want State-specific data. But on other things, we may want to look at kind of the national picture and draw conclusions about how well the program is working.

Trish?

COMMISSIONER RILEY: I was concerned about the same thing. I think the Commission needs to decide what our focus is and what our purpose is. If part of the survey's purpose is to be able to give States comparative data to check their access boxes off against each other, then we need an extraordinarily robust survey, because even for little States, CPS has been used so -- the uninsured example is a great one. States are doing their own data on surveys on uninsured status. The CPS comes out. Even the clear understanding within the CPS itself is you can't use one-year data in these little States. Of course, it got used and there was dueling data everywhere. So even with all the caveats about how data can be used, it will be used to make determinations that this State has an access problem when, in fact, it might be a data problem.

So I think we have to think about what we want. Do we want a snapshot, as you were saying, Diane, as a Commission, a snapshot of access for the Medicaid program nationally on some levels? Do we want comparative data State to State? And if we want that, we need something far more robust with a deeper sample size so that we don't have dueling data and we have really clean -- we don't have debates about the methodology forever.

CHAIR ROWLAND: We need to go to, for some State samples, three-year samples that then have a mix of policy options in them and don't work perfectly.

COMMISSIONER RILEY: [Off microphone.] -- publish them that way.

DR. O'GRADY: Right. I was just going to say, and it does get into the nuances of what are the real policy questions you want to answer, because we've talked about kind of State-level estimates. But once you get to State level, you might want to know racial-ethnic within that State. You might want to know language spoken at home in that State. There's a number of things, and so that's even more sample size and what not.

So it is quite true that you want to have the methodology well enough, and we see it in other areas. Certainly, the clinical

trial data, you'll see that as they try to move out from the 500 people that they did that were in the trial and move out, they do start to collapse CDC data into two and three years to both be able to do racial-ethnic, to do different States and things like that. So you do want kind of your methodological rigor to be there, because this is as important as almost anything we do at NIH or science. I mean, this is people's lives and a lot of money, so it's important.

But you just need to think about where you're going to pick your shots, where you're going to do this, and what is the best way to get you there.

EXECUTIVE DIRECTOR ZAWISTOWICH: And -- oh, sorry.

COMMISSIONER CHECKETT: Just two comments there. In States that have capitated managed care plans, there is a significant amount of reporting required by the plans to the States for their EQRO reviews. How easily that could be sent forward to us or to CMS, I don't know, but it is very, very extensive, having gone through those a number of times. It will tell you a lot about access. It won't necessarily tell you anything about utilization. But in terms of what is a contracted network, where is it, a lot of guidelines about that. So that would be something that might be actually inexpensive, laborious but inexpensive to obtain.

And then, obviously, I want to really emphasize the importance of whatever survey methodology or tool we use, we have got to be able to differentiate between the populations because I think that's where we see critical differences in how people are able to access care, who uses what, why, et cetera. But very great differences among the diversity of the Medicaid population.

MR. PETERSON: And the only thing I'll add to Mike's stuff is that NORC is working on a report that will be more detailed, a more detailed analysis of what these options would entail, what the trade-offs are. And so that will be more fully formed next month.

CHAIR ROWLAND: Mark?

COMMISSIONER HOYT: The access issue is linked to the early warning system thing that we're going to work on, as well. If the scope of that is meant to be national, then it seems like we have to go national with this issue, as well. Otherwise, it's going to fall apart.

CHAIR ROWLAND: A lot of food for thought and a good start at looking at a complex issue, but one that really is going to be the underpinning of what we can do in our analytic effort and building an analytic base, so I know we'll continue to be discussing it.

I want to thank you, Mike, for coming today and for the

work you're doing for the Commission, and Chris, and we'll move on to our next topic --

Thank you.

DR. O'GRADY: Thank you.

[Pause.]

CHAIR ROWLAND: All right. Let's bring the next session forward, please. We want to welcome Marsha Gold, a senior fellow at Mathematica Policy Research, and our analyst, Lois Simon, to a discussion today of building an analytic framework for Medicaid and CHIP around the managed care issues -- another area where I'm sure data, information, and analysis are all going to be a challenge, but will be central to the work of this Commission.

So, without further ado, let's kick off our next discussion. Thank you. Can you turn the mic on? Thank you.

BUILDING AN ANALYTIC FRAMEWORK FOR MEDICAID AND CHIP MANAGED CARE

OVERVIEW

DR. GOLD: Thank you. I'll try and be brief. Hopefully you've had a chance to review the literature review and the expert panel meeting summary that we did, and I know staff want to have time so you can have discussion.

What I want to do with you is very briefly hit some of the high points of the literature review and expert panel, and what we were looking at there was what we know about oversight, access, payment issues associated with Medicare and CHIP, where are the gaps, where are the emerging needs.

I should note that while on some of the data that Lois and I have been working on we'll be covering all of managed care, on these we really drilled down into the comprehensive risk-based programs because most of the enrollees are there, there's unique oversight issues, and also those plans have the most issues raised with exchanges. So we haven't forgotten the other parts, and that will be covered in the report. But this is on capitated plans. And so what I want to do is go through what we see as the short- and long-term policy concerns and Commission priorities.

So key findings. I don't think I have to tell this group that, but it comes out so strongly in the literature that each state is different. The environment's different. The program's different. The health delivery system's different. And this is going to continue as enrollment in risk-based programs go, and it makes it very different than working with Medicare where your markets differ but your program's the same.

So that explains in a lot of ways the third bullet, which is that the findings on all this stuff are mixed. It depends on the state, the market, the metrics used, as to whether managed care is -- how it compares with fee for service, how it compares to the private sector, which has a lot to do with your monitoring issues and complexity that you're dealing with.

However, one finding that comes out really strongly across all the studies that have been done is that it takes a long time and it's hard to do effective administration and oversight, and that that's critical to how well a new initiative works out in creating strong programs. So I think as we talk about Medicaid expansion and exchanges, that's a real issue to be concerned about.

Then the other point that comes out, looking at some of this literature, is when you look at the managed care plans and their performance, some of the issues are not distinct to managed care. I mean, the payment rates, the budgets are lower; provider performance is an issue; some of the people live in areas where there aren't a lot of doctors. That's not even unique to Medicaid. It's unique to poor people in the system. And others are sector-specific concerns, and I think as you move towards building an oversight system -- and we'll talk about this -- figuring out what's the same regardless of

which program you're in is a similar policy concern, and what's unique is an important issue for having something that's robust.

Next slide.

COMMISSIONER CHECKETT: And, Marsha, I have a quick question. When you're talking about managed care, are you including the PCCM programs in that phrase? Or is this just on --

DR. GOLD: Right now I'm really talking about the risk-based program.

COMMISSIONER CHECKETT: Okay, great.

DR. GOLD: Some of the things apply to all, but most of the research has been on risk-based programs.

COMMISSIONER CHECKETT: Great. That's an important distinction. Thank you.

DR. GOLD: And that's what I'm focusing on here.

Next slide?

There's a lot of limitations in the research. It really is obvious for those of us involved that nationally, at least, there hasn't been a lot done since the late 1990s and early 2000s. The states have done a lot, but there hasn't been much focus on Medicaid managed care. At that point most of the programs covered low-income people, you know, families and children, so we know less about aged, blind,

disabled, and that's not one group. It's about 17 different groups, at least. And that's very complicated.

Getting into the black box is something I worked on a lot years ago, and I know Sara worked on it and others have worked on it. It's difficult and there's very little ongoing data nationally to do that as to, you know, who's eligible to be a managed care plan, what licensure requirements, what contract requirements. How is the benefit package design? What carve-outs are there? And what management features are in there? How does the money go? What are the rates that go to the plans? How does that go to the providers? And how does that affect care?

And so we know a lot, I think, from past research about how to look at some of those things, but ongoing data for monitoring -- and Lois is going to pick up on that -- is really limited.

And, finally, you know, I was amazed, I looked at the CHIP evaluation reports, and they're all enrollment. There's nothing on the plans that are in there.

So on the expert roundtable, we tried to -- there's a lot of meat in those reports, but what we tried to do here is just sort of, because it's a federal program, differentiate what the concerns are by level of responsibility. So the states really run those

programs, and as we mentioned, there's a lot of variability in them, there's unevenness, and one of the messages that came out really clearly to me is just how stretched states are, and also the problems with antiquated MIS systems. So one of the issues that came up is to what extent there's a federal role for sort of helping some of these states, if they want to, you know, deal with some of those things, because at the federal level there the issue is accountability for adherence to national goals. And there's problems of oversight. The regional offices, GAO has brought up those problems. There's not a lot of good performance data for monitoring. Some of it, there's more things maybe that come into CMS, but we don't know what happens to them or they're not used that much. And one of the things we're trying to do is figure out what they really have and what that means for how you can monitor it.

At the federal level, the real challenge, I think, as I've watched things over the years, is how you balance this oversight for national program goals with the state flexibility that really is both inevitable and also called for under a federal program.

And, finally, both states and federal government, the need for coordination against Medicaid, stand-alone CHIP, and exchange is important. The types of plans that are in Medicaid may not be the

same as the ones that are on the exchanges, or may. There are issues with how that all relates when people move across. And then, finally, the panel emphasized the importance of monitoring in real time, but also noted that it required multiple metrics.

So let me quickly go on to some of the -- talking about what this may mean for oversight, and this slide I think probably harkens back to your access discussion as well. It seems to me that program-wide, when you look across things, there are concerns that are common to -- no matter how you do it, whether it's Medicaid, fee for service, or anything else, you want to make sure beneficiaries have informed choice, whether they understand the options and trade-offs. You want appropriate access, whether they can obtain access to mandated services regardless of the plan. And I want to note -- and I'll share it with staff -- that PPRC did some work on access in Medicaid earlier, and I've worked on a paper where we looked at how plan rules affect access as well, and so it's access and use. And that fits within the IOM framework, but it looks at a piece of it. And so the question is where the access monitoring fits with the broader monitoring of oversight on dimensions, and that may be your way of dealing with different concerns you have that there's different pieces, and maybe the survey deals with the specific access to services

and the other pieces deal with other dimensions and it's all part of a whole. But I'll leave that for you guys to figure out.

[Laughter.]

DR. GOLD: Then there's also fiduciary responsibility, administration, effective oversight, and, finally, emphasis on value. No matter where people get care, it should be good value, whether it's coordinated, evidence-based, high quality, and efficient.

I think where some of the challenges come up is that the oversight concerns are different in Medicaid capitated plans and fee for service. They overlap a lot, and the dimensions of concern are similar, but because they're paid differently the risks are different. So on capitated plans, because they're paid on a capitation rate, the theoretical risk or the concern is that they'll be underused and enrollee risk selection. So that's what your concern is. In the fee-for-service side, you're concerned they're going to use too many services and expensive services. So those are different.

In the capitated plans, because they're paid on an aggregate basis, the concern is to make sure they're not profiteering or diverting funds to other purposes, including some that Congress has sometimes used, and then it's okay because Congress says you can do it, like a cross-subsidy. But on the other side, there's a risk of

fraudulent billing, and that's been a concern there.

When you have a risk-based payment through plans, the risk is that there's layering and that will lead to administrative costs for functions that have little value. And notice I'm saying that, because some functions have value. So the key is to make sure you're getting value for your money.

On the per unit payment side, the risk is that there's too little funds to coordinate and make this stuff fit together. So on the capitated side, your oversight is to maximize the potential that the capitation results in patient-centered care -- not inpatient, but patient-centered care, that's coordinated and hold providers accountable; whereas, on the fee-for-service side, what you're trying to do is complement fee-for-service payment with other things that build in some of the care management features.

So in terms of -- Lois, the next slide -- critical questions to guide MedPAC's discussion, I think -- oh, I'm not going to spend time on this. I originally had -- there's a lot of different levers, and that's the point that you can use to influence them. We have more detail. We can go through them if people want, but there's a lot of ways that you can influence them.

So, finally, on the questions that are critical, I think

it would be useful to see if the Commission feels that, you know, given what we've laid out, whether that makes sense and which concerns are unique to managed care compared to the entire program as a whole. What we worry about with managed care -- with Medicaid and CHIP today versus in an exchange environment where people are moving across these programs, and we've focused here mostly on the sort of general garden variety managed care. There are some unique concerns for specific sub-groups and, you know, which differs. When people are mainly income-eligible, are the concerns the same as private insurance but it's just an income difference versus specific disability needs, and that has an implication for oversight as to whether you're equally concerned across all types of eligibles or for certain types of eligibles, whether there's more concern than others. Then, you know, looking forward, once you know the issues, what do you want to address? How does this fit into an early warning signal? For example, if you wanted that survey to be able to differentiate managed care from not, your sample size gets even bigger, and so does the sub-groups. But in any case, you can sort of figure out where it fits and what are the short- and long-term policy goals and what your priorities are, because one thing that was clear from the panel -- and I'm sure people here who are involved with states are aware -- people are really going

nuts. And so the question is really what's the most important --

[Laughter.]

DR. GOLD: No, I mean, you know, it's what are the key priorities, and so leverage is figuring out what's going to be most important going forward and focusing on it. Sorry.

CHAIR ROWLAND: The quote of the day.

[Laughter.]

DR. GOLD: Lois.

CHAIR ROWLAND: Explain how we go sane, Lois.

DR. GOLD: I meant the states.

VICE CHAIR SUNDWALL: It's where we're from.

DR. GOLD: Right.

MACPAC WORK PLAN FOR MANAGED CARE

MS. SIMON: Okay. So I'm here to introduce the proposed work plan for Medicaid and CHIP managed care. It is one that I think reflects both the comments that we've heard yesterday, today, and the last two Commission meetings, as well as addresses many of the gaps and needs identified just now by Marsha.

At the last Commission meeting, digging deeper into exactly what is Medicaid and CHIP managed care came up a number of times.

From your discussions came an interest in learning more about the characteristics of state managed care programs today as well as in a post-health reform world. And Marsha's literature review and the expert roundtable highlighted the fact that research is limited with mixed findings and is often outdated. With the significant growth in managed care in recent years, as well as the changes in market dynamics, it seems important to build a profile of state programs to better understand their key traits.

Also, while it is known that tremendous variation exists, which we hear over and over, there is little descriptive state-specific information to be able to make state comparisons, and we think this profile will enable us to do that.

For the first year, we'll provide a baseline, and we envision collecting information over time to provide the ability to track trends into the future. And this we see as most important as we try to understand managed care's role as we move towards 2014.

Our goal here is to build a comprehensive profile of Medicaid and CHIP managed care programs throughout the country. We want to be able to get into that mysterious black box that kept getting mentioned at the last meeting. So I'll go over our thoughts on where MACPAC could focus its efforts, but we're really looking forward to

listening to you and what your priorities are.

Regarding program design, for each state we would gather basic information on the populations enrolled, managed care models that are being used, so both risk-based and PCCMs; plan participation requirements and which services are in plan benefit packages and which ones are carved out.

Yesterday Deborah mentioned plan contracts require plans to maintain a sufficient number, mix, and geographic distribution of providers, but, again, we don't know what does this mean in each state. What are their specific requirements with regard to provider ratios, distance travel times, standards? And, again, for both primary care and specialties.

Market dynamics in Medicaid managed care have changed considerably in recent years. We talked about that some at the last meeting. Commercial plan participation has declined while Medicaid-focused plans have gained market share. Also notable is the emergence of a number of large multi-state publicly traded plans. So it is important, we feel, to understand these changes, what types of plans participate, their ownership types, whether they are publicly traded, and how the mix of plans change over time, and also what are the potential implications with regard to quality of care.

Yesterday -- and Donna has brought this up a bunch -- there were questions on what data states require plans to submit and how the data are used. At the panel discussion, plans said that they are doing a much better job with submitting good encounter data, so we want to know more about the collection and the use of encounter data. And, further, the panelists at the roundtable agreed that an ongoing monitoring system must include measures both up front and on the back end. So developing a state-specific understanding of how states oversee and manage the collection and analysis of information, such as complaints, HEDIS, grievance and appeal process, and provider capacity standards, we think would be beneficial.

And, lastly, we want to learn more about how states set premiums, the accounting of administrative and medical costs, and the various types of risk adjustment methodologies that are being used.

Marsha brought this up a bunch, too. The potential role of managed care and coverage expansions heightens the need to make sure that oversight of plans, both from federal and state levels, is effective. So we propose taking a look at CMS oversight practices related to tracking states' compliance with monitoring their managed care plans. What steps does CMS take? What types of reviews occur

-- contract reviews, on-site audits? What are the reporting requirements? Also, with what frequency?

Breaking down the different responsibilities of CMS' regional offices versus the central office is something we also would want to address.

Also of interest is understanding what auditing and oversight activities states take to ensure that participating plans are meeting their contractual requirements, and we hope this information will lead us to a discussion of what is the right balance between federal and state responsibilities.

Come 2014, for many individuals their eligibility will fluctuate between Medicaid, stand-alone CHIP programs, and the exchanges, creating challenges on how to ensure seamless coverage. Delivery options, provider choices, and benefit packages could all differ among the different programs, so questions to be addressed in this area include: What are the likely differences among programs? And how can continuity of benefits and care be maintained? Will increased enrollment in both Medicaid and exchanges put added pressure on access to care for low-income populations? And will plans, especially those offering both products, have sufficient network capacity?

Also, health exchanges will provide new opportunities for both commercial and Medicaid-focused plans. Plans with Medicaid experience can expand beyond Medicaid products, and commercial plans can choose to gain entry into both Medicaid and the exchange. So what models will participate in which programs? And what do we see as the risks and challenges of this shifting landscape? And, lastly, how will states choose which plans can be sold on the exchange?

So for this analysis, one thing we would like to do is focus on managed care, full risk, and PCCMs, but also on the fee-for-service side because we feel that it's really important that all beneficiaries should be able to move smoothly between programs.

So our next steps, with Marsha and Mathematica, we will begin exploratory work to determine first what information exists with existing sources and then where we will need to collect our own data. We also know that we can glean a lot of information from other MACPAC efforts. For instance, the state survey of Medicaid directors that HMA is doing for us and will be presented in the next session will provide us a lot of insight into what states do to assess access to care, and a lot of that is on the managed care side.

So given what Marsha has told us and what I just presented, we look to you for guidance. What do you see as our priorities both

in the short term as well as in the long term?

CHAIR ROWLAND: Thank you.

Donna, I see your light on.

COMMISSIONER CHECKETT: Yes, I do have a couple of questions, and one would be to Marsha. I was curious when you said that the ABD and dual population, which have a long history of being enrolled in managed care, has not really been researched very much, and I was wondering if you could explain if there are particular barriers to that and why is that the case.

DR. GOLD: Well, I think some of it is that the federally funded research on Medicaid managed care really sort of stopped at the end of the Clinton administration, and a lot of the new initiatives coming on with them. I think that's accurate. And some of the states have done their own work. I mean, I think they would say they've looked at things and they've submitted waiver requests, but the quality is more variable.

I think probably the biggest problem is that it's such a mixed population that sort of just even figuring out what you found out, if you look at it, which sub-group is it, is very complicated. So it's not easy stuff. I mean, there's the duals and then -- but there's the mentally -- I'll have the words wrong, I'm sorry, but,

you know, the developmentally disabled and the mentally ill and there's people who have everything and young kids. There are so many sub-groups with special needs and delivery systems that it becomes very difficult to look at. But I think the largest reason is that there hasn't been really a lot of national money, either in foundations or in the federal government, over the last ten years to look at these efforts that states have done.

MS. SIMON: And I'd actually say even that there's not a lot of national efforts. I think we'll find that there are a lot of state efforts that have been done, and we've got to try to figure out that, because me coming from New York State, I know we did a whole survey on the SSI population after we enrolled the SSI population into managed care. But that's something that, you know, actually we wouldn't --

DR. GOLD: And it's hard to get, too.

MS. SIMON: It's hard to compare, too.

DR. GOLD: For the lit review, Jessica Nysenbaum, who worked with me on this -- and I should acknowledge her hard work -- you know, went through some of the websites to see if we could see what states had on there. And, you know, you'd come across the usual annual report to legislatures, but finding the really solid data is

not very easy. So one of the questions, too, is: Is there a way -- I mean, why is there not more sharing and what barriers, if any, are there to making all this stuff that states have done when they've done it available more easily through vehicles that reach states?

CHAIR ROWLAND: Marsha, wasn't a lot of the earlier evaluation done as part of the 1115 waiver evaluations --

DR. GOLD: Yes.

CHAIR ROWLAND: -- which then stopped, pretty much.

DR. GOLD: Yes.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: We did a study in 2002 comparing separately administered CHIP contracts to Medicaid contracts and noted some very major differences at that point, which, of course, had to do with the fact that in separately administered states the benefit design is different from what it is for Medicaid in a lot of the states. In some of the states, it's quite similar. And so if you're going to reproduce contract collection work, I would suggest that we really focus on the MCO contracts. I mean, the job is just absolutely immense, as you know.

COMMISSIONER CHECKETT: I'm sorry. I didn't hear what you said,

COMMISSIONER ROSENBAUM: I would suggest that we focus on the MCO contracts, not just risk capitation but the comprehensive contracts, the ones that bear the most resemblance to what an exchange contract will look like, what a CHIP comprehensive contract looks like; that we also focus on those states that have not, for all kinds of reasons, jury-rigged -- and I don't mean that pejoratively. I mean that because they've had to for political reasons jury-rigged carve-out arrangements. I think what we really want to focus on are the MCO contracts that are all-inclusive contracts, so that whatever benefits are contracted out are in a comprehensive agreement, because I think given the magnitude of this job and given the long-term consequences or implications of your work for exchange products and seamlessness between markets, it's those contracts we really want to understand. When a state goes about buying a comprehensive product today, what is it trying to buy? And then, secondarily, if you have time, obviously, what I would call the limited benefit contracts, the PCCM arrangements, the carve-out arrangements, but I think most important are the contracts that are comprehensive both for the non-disabled, non-elderly populations, and then separately in states that are using them for populations, and maybe the same with supplements, obviously, for populations with additional health needs.

Within that I think the most important thing we absolutely need to understand, again, looking down the road to 2014 and looking at this problem of movement between markets, is what is the Medicaid custom today. What does a Medicaid agency feel comfortable out of its entire state plan, including the EPSDT benefits, which are actually technically not in the state plan, but treating those as state plan benefits, what does a Medicaid agency feel comfortable putting into a risk agreement today, even if that risk agreement has, you know, stop loss corridors and things to cushion the plan against full-blow risk? And what things are agencies continuing to keep out of their contracts? This was the issue we wrestled with for almost a decade in our work: what's in, what's out. And as we move toward sort of market standards for low-income populations, I think it's really key to understand both what Medicaid agencies see as viable markets and what things they think either for, you know, parochial reasons or because they know the limits of the market, they are keeping out of their contracts and treating as a direct pay issue. And the complexity of this is that it's often not entire benefit classes. Certain things go in up to a point, and then there may be extra benefits that are left in the fee-for-service market that a Medicaid plan may have some coordination responsibilities with but is not at risk for.

And teasing that apart is going to be -- I think that and the networks issue, how agencies describe both the composition of networks and their obligations that are important.

The only other thing I would add is that from my experience with this work it's obviously -- often the problem is -- and it's probably the most nuanced work that the Commission will do. It's not black and white, because the terminology that's used -- you'll have 50 states that are all doing X, and the difference is often how they characterize what they're doing. So it's a place where the content, the terms obviously really matter.

DR. GOLD: If I can sort of -- I think I want to caution the Commission that on the level of detail they can expect, that MACPAC can do both with the time frame, the resources, and legitimately what it is. I mean, you could get lost in these data and come with nowhere, and so it’s really hard to get this stuff.

I think, hopefully, it’s enough at the big level to help figure out what’s missing on some of it and ask questions, but figuring out what’s most important from the Commission’s perspective is going to be really important because, Sara, you spent years working on that compendium. I don’t think, you know, the Commission probably has that luxury.

COMMISSIONER ROSENBAUM: No.

CHAIR ROWLAND: We clearly don't have years.

COMMISSIONER ROSENBAUM: No. It's why I'm recommending that we stick to one type of contract.

DR. GOLD: Yeah.

COMMISSIONER ROSENBAUM: And that we try even putting the ADD population aside for a moment and deal with families with children and ask several questions of the language in the contracts, because this is huge.

COMMISSIONER GABOW: I am full of comments and questions. Marsha, could you talk about what your data has shown, or Lois, about quality care because in Colorado, when we look at our managed care versus fee-for-service versus PCCM, it's very clear that for the 20 or 30 measures that we look at, that the people who are in managed care are getting more appropriate care in terms of process measure and also in terms of outcome measures like controlled blood pressure, et cetera.

And it makes sense, from your little table, that there's more coordinated care. I also think, because of the nature of capitated payment, the patients who are in managed care have many more options about the nature of the visit. That is to say, they can

use an advice line, there can be telephone consultation. Not every encounter is limited to a face-to-face encounter, which is driven by a fee-for-service model.

So the first question is, how about the efficiency of the care and the quality outcomes? The second question is, it seems to me that it's very hard to begin to talk about bending the cost curve in a fee-for-service model. And so, some thinking about the economic efficiency of the two models, I think, is extremely important as states and the Federal Government worry about the costs.

The third thing I would just caution you on, I know the last discussion, Lois, was about oversight, but I can tell you the administrative burden put on us, everybody and his brother in the managed care arena, is wasteful. It's very hard for me to see the value added, and I really think that we have to understand evidence-based regulation as well as evidence-based medicine.

I just think that there's a tendency to say, well, we have to make sure that these managed care companies are doing these 27 things and we're going to have four audits a year and we're going to ask them to report 10,000 variables. It's lethal and wasteful.

My final comment is, I agree with Sara in that we should look at the pure capitated models, but I think we have to look at

the carve-out of mental health as we look at that because I think it would interesting to know how many have a carve-in of mental health in managed care and how many have a carve-out.

I think to the extent that we can look at the outcomes efficiency and efficacy of the carve-out versus carve-in models, because as we know, this population has a statistically much higher substance abuse and mental health issues and they're generally asked to navigate two extremely complex independent systems, which can be economic or useful for outcomes.

So I think that while I agree we want to look at those that have everything, I think it's very common to have the mental health out and I think we should think about that as a separate bit. So those are my four comments.

DR. GOLD: I'll try and do really quickly on each of them. In terms of quality, I think you're right. That's a lot of people's hope that managed care, especially for some of these more severe populations, will improve quality. The data are mixed across states. It depends how well the program was. It depends how well the fee-for-service program worked.

One of the problems is that if you want to look across states, there isn't a very good way to do it now to come up with an

answer. So while I tend to agree with you, I think there's more in the way of data.

Efficiency and cost savings, some of that may differ short and long term because it takes time to get these systems up and that takes awhile. I think with the particularly severe people who cost a lot, the potential may be greater. The issue is what the underlying access was before, because one of the questions is, if there were problems and you build that into the rates, you're going to continue the problems.

So figuring out whether you want to have savings or whether you just want improved access or what that trade-off is makes it difficult. But certainly, I think a number of people are concerned -- see potential in looking at some of these complex patients in terms of the savings you could get.

Evidence-based regulation, I just agree with you. That's a policy decision, but I agree. And pure -- the carve-outs. I think we've done a little work on them. My guess is that may be something that is hard to address this year, but one could get some data and start to address it next year.

They become important, but they also get intertwined with how states have supported their inpatient mental health system and

if they've medicalized everything and used the Medicaid funds to support the inpatient hospitals, that's part of the reason they have the carve-outs and it gets very complicated.

So I think we certainly need to be able to begin to talk about that, but to do justice to the policy issues and complexity, both from the patient perspective and from the fiscal arrangements it's going to take a little more --

CHAIR ROWLAND: We should potentially add that as a specific long-term research goal. Donna, did you have --

COMMISSIONER CHECKETT: Denise was before me.

COMMISSIONER HENNING: I also think that when you talk about special populations, you have to also consider pregnant women and obstetrical care as a particular special population in that it's a short period of their life, but it's a very intense period of care where they're accessing care multiple times.

So if you followed the ACOG fee schedule, you would be seeing that person 13 times during that pregnancy, assuming they delivered at term. Most Medicaid systems have a limit on the number of visits you can be paid for if it's fee-for-service, which is like ten, but then if you try to put them and fit them into a managed care system where you're getting paid a very minuscule amount per patient to take

care of her and take care of her for that many visits, I don't see how you make money, make ends meet, and keep your office open if you were under a managed care system for that kind of care.

DR. GOLD: There's some real cross-over issues between managed care and fee-for-service in that because the question is when they get eligible and whether they're in managed care. It seems to me that probably the most reasonable thing at this stage is to figure out how the states treat eligibility, whether pregnant women go into managed care, at which point, and sort of get a sense of whether this is a managed care issue in a lot of states or it's a broader issue. Unless I'm missing something?

COMMISSIONER HENNING: I think most states are moving towards managed care for everything Medicaid related, but including OB care.

DR. GOLD: But if they don't get in until their eighth month, what can you do?

COMMISSIONER HENNING: No, I mean, they get in pretty much --

DR. GOLD: Oh, okay.

COMMISSIONER CHECKETT: I've just got one issue to bring up as well and it's more, I think, a comment to the Commission as

much as to our consultants. But I think we need to really focus, at some point, not by March, but soon, on what it's really going to mean for Medicaid beneficiaries in managed care plans to be moving and cycling in and out of exchanges.

I think a real opportunity for the Commission is going to be for us to be a voice independent of CMS that alerts Congress on what we need to watch for. There are tremendous opportunities, tremendous opportunities and great pitfalls. And so, I just want to put that out there for something else for us to think about.

CHAIR ROWLAND: Other item for your list. Richard and then --

COMMISSIONER CHAMBERS: I just wanted to echo Patty's comments about the behavioral health and in talking about a long-term issue -- no pun intended -- but long-term care, managed care, also, which is moving forward. I think it's as critical, as Sara also said, is the bringing together of understanding the carve-outs, the impact as we focus just on the acute care side. For someone who runs a plan that has acute and long-term care and in trying to integrate behavioral health, how difficult it is, but the impact it has on just the acute care delivery side and outcome and cost and performance with the carve-outs.

DR. GOLD: One thing I should say that I think we're going to do, and I think that we may even have it in time for you to consider it in the March report, is just look at the current way CMS classifies all these managed care enrollees in the monthly enrollment -- the annual enrollment reports, and which programs these are, because some of that data is really -- it doesn't make any sense.

So it seemed like it would be a fairly low-hanging fruit to have the Commission sort of look at what may be behind it and some of that is the commercial and the managed care, but also, some of those, the carve-outs and where they end up, if they're managed long-term care and how they count or don't count, I mean, some of those other plans are just transportation.

CHAIR ROWLAND: Patty?

COMMISSIONER GABOW: One thing about managed care is the states -- and you alluded to this a little bit, I think -- the states' ability to actually manage these plans effectively. I know one of the big issues for us in the plan is who's in and who's out. When they do an audit two years later and say, well, you owe us X dollars because these 100 people were actually dead when we assigned them to you --

DR. GOLD: Oops.

COMMISSIONER GABOW: No, I mean this whole --

DR. GOLD: You're talking about the rate setting reconciliation later on.

COMMISSIONER GABOW: And that, I think, is a big issue for providers. And so, as we look at managed care, I think -- and the exchanges are going to add to this -- is, do they actually have the ability and the infrastructure to effectively manage this in a timely and appropriate manner?

CHAIR ROWLAND: And on that note, I think that --

COMMISSIONER MOORE: Can I just say one more thing? I think this is incredibly important, but from the standpoint of everything we've heard today, this is probably a subject that more than most needs a prioritization for us that the staff can put together, because we could spend more than full-time on this, and when we need to figure out how to sequence it and stage it.

CHAIR ROWLAND: And with that, I want to thank Marsha and Lois for starting us on the road to looking at this issue. We'll take a ten-minute break and then reconvene. [Recess.]

CHAIR ROWLAND: If we could please take our seats. Commission members, please return to your seats.

[Pause.]

CHAIR ROWLAND: In the nick of time arrives Vern Smith.

As everyone is well aware, one of the main charges to this Commission from the Congress was also to develop an early warning system on access to care. We've spent some time this morning talking about a definition of access, which is still a priority that we will need to work on and to look at the various dimensions, but we wanted to at least in this session begin to talk about how to think about an early warning system, how to think about what access to care means and how to look at potential early problems. It's going to be a major piece of what we will be working through, and this is, again, a beginning discussion, not an end point.

I want to welcome both Vern Smith, the Principal for Health Management Associates, and Andy Bindman, the Director of the University of California Medicaid Research Institute, known as CAMRI, to our discussion today to really kick off some of the key measures. And we appreciate that Vern has just come into National, scooted over by cab, and I don't know if you want to catch your breath and have Andy go first or if you want to start. Whatever order you two want to go in is fine.

DEVELOPING A FRAMEWORK

FOR AN EARLY WARNING SYSTEM ON ACCESS

REVIEW OF STATE APPROACHES TO MONITORING ACCESS

DR. SMITH: I would be happy to go ahead and jump in. I think that was the order we were going to do it in.

CHAIR ROWLAND: Okay. Welcome.

DR. SMITH: I'm not sure whether to say Delta Airlines is a reliable business partner this morning or not --

[Laughter.]

DR. SMITH: -- but we've all experienced that.

I'm very pleased to be here and very pleased to have a chance to work with MACPAC on these really important issues. Today, what I'm going to do is to kind of go through a brief set of slides to kind of whet your appetite for some results which we hope to have completely ready to present to the Commission at the January meeting.

We have initiated a survey of State Medicaid programs on the issue of access. The purpose of the survey really has been to try to learn from the Medicaid programs how they're looking at access right now, what's a practical, reasonable, feasible way, something that would actually work for Medicaid programs in terms of having an early warning system.

So far, we've had some good responses from the States. A couple of States have indicated that they're a little reluctant to

respond to a survey like this because of some actions which are underway in their State right now relating to access, some litigation. But other than some initial responses we had along that line, we've been getting some very complete and comprehensive responses from States. So I'm looking forward to, over the next few weeks, being able to put together some very good results that will be beneficial to the Commission.

We developed a survey with consultation with MACPAC staff. It has seven questions. I think you all have had a chance to maybe look at the survey, so you know what is there. It went out on the Wednesday before Thanksgiving, which you might think would be a bad time, but given Medicaid directors, we began receiving responses right away, and the responses have been coming in this week, as well. So as I said, we are going to be giving you some preliminary responses this morning.

What we found is that States are using a variety of ways to address the issue of access. The primary way of looking at access for most States is through their managed care contracts. So what we're seeing is a number of States responding that they have provisions in their contract itself, and several of the States indicate that they are doing very expensive, and I would say from the results we've

gotten so far, sophisticated methods of monitoring access.

I was thinking perhaps I could maybe just quote from one of the surveys that we just received, keeping in mind that we have promised all the Medicaid directors complete anonymity and confidentiality in the responses, so I'm not going to be telling you where this came from. But a State with a large managed care and sophisticated managed care monitoring program, and they have a report which they monitor for their fee-for-service and the State also has a PCCM program which they have some standards for. They look at these reports on a quarterly basis.

And on the managed care side, all the plans are required to report network adequacy. These reports are monitored on a regular basis. The managed care plans submit geoaccess reports which then are analyzed to see if they're -- exactly how far away geographically are beneficiaries from the providers that they're using. They have different standards for children than for adults.

States also test access by anonymously calling providers who are said to be in the networks of managed care plans to determine their actual status, are they taking patients, how long would it take to get an appointment, and something along that line.

And then the plans themselves are also required to report

out-of-network utilization, so there are specific methods for monitoring emergency room use, primary care doctors out-of-network, specialty care out-of-network, and those kinds of reports are suggestive of any access issues that a State might be experiencing, as well.

And then one of the other methods is to listen to the transportation brokers to see what their experience is.

There are also -- one of the questions is, if you had an access problem, how would you know it, and so what States are doing is looking at feedback from the members, feedback from their health plans, looking at their analysis of the HEDIS measures, some of which are access-specific, as well as CAHPS. CAHPS, I am sure you know, are patient experience surveys, kind of a patient satisfaction survey.

I think I went over this slide already. Monitoring -- well, and if you then find a problem, what would the State do to try to address it, and one of the things which is clearly referenced is, well, if there's a problem and it's with a health plan, one of the things they would do is to look at a health plan -- contact the health plan and actually perhaps survey all the health plans to kind of determine if this is an issue that is specific to a health plan or if it's kind of across all providers. And then there are processes

in place which are described in the responses where States would maybe work with a medical association or medical society to try to address it to kind of see if this is a Medicaid-specific issue or something that goes across Blue Cross and other commercial insurers.

So there was a question also about whether States monitor the supply of providers. For Medicaid programs, this is really not something which Medicaid programs do a lot of, but they may be aware because of the other activities that they're doing, may work with the medical community or with other parts of State government to look at the geographic location of providers and see whether or not there is an issue. They track the participating providers. This is really kind of a network analysis process that States go through.

In terms of using the HRSA standards, it's kind of been, so far, kind of a split between those that do, those that don't. Some of the States that don't specifically say that they use that information to inform their own analysis. Some States have commented that it would actually be helpful for them to have some national guidelines in terms of access, but States also indicated that if we're going to be doing something here -- this kind of gets to the early warning system -- that information isn't free. There's a cost to information and so the cost of any expanded monitoring effort needs

to be considered.

In terms of what we're doing -- that's kind of a summary of the findings that we've had so far, and I expect to have a much more extensive report ready when we see you in January.

What we're doing now, actually, is beginning to follow up. We don't have the full response, but it's only in the field, of course, for a couple of weeks. But it's time now to start doing some follow-up among those States we haven't yet received the survey from. We'll be doing that. We're also going to be following up with some of the States that have responded to get a little more in-depth response from them and we'll be putting together a paper which you should have in time for the next meeting.

And we want these results to inform what CAMRI is doing, so I think that's maybe a good point of handoff. Andy?

STATE PUBLIC HEALTH SURVEILLANCE SYSTEMS AND INITIAL EWS CONCEPTS

DR. BINDMAN: Terrific. Good morning. So I will pick up where Vern handed off and sort of take a step back. This will be our kind of a foundation building about how we're thinking about the early warning system and an opportunity to get some feedback from you, and we will also be planning to come back with a longer in-depth

description of this in January.

So our task at CAMRI, the California Medicaid Research Institute, was to provide a framework for kind of understanding the factors that determine access to health care, understand and try to apply some of the lessons that might be learned from current public health surveillance systems to see what methods they may be offering that would be relevant for an early warning system, try to identify some of the key challenges in building an early warning system and some of the characteristics of what we think a good early warning system would look like.

In terms of looking back at the law and what it says about what we're trying to accomplish here, our goal with an early warning system is to try to inform policy on the impact of Medicaid and CHIP programs on health care access. For our purposes, we, and this circles back to a discussion from this morning, we also thought that the Institute of Medicine definition about access and the timely use of personal health services was probably a very good starting point. Obviously, you heard some of the feedback around that this morning and we'll take that into consideration as we move forward, but this has been a framing issue for us as we have started to think about early warning system.

The additional parts of an early warning system are to attend to being able to monitor over time, and this is particularly relevant, of course, if the number of beneficiaries grows, as is anticipated under health reform, and to think about how to identify sentinel health events that might be indicative of significant access barriers to high-quality care.

In addition, it's going to be very important because of the nature of the Medicaid program to be able to geographically locate the access problems and not just sort of say in general, which has often been available from national surveys and sort of summary statistics of, gee, is Medicaid working as well as private insurance or differently than other kinds of insurance, but to be able to specifically get into geographic locations where there are access problems and therefore once identifying those to be able to provide an opportunity to dig deeper into which subgroups are impacted, what is the extent of the barriers, what are the reasons for this happening, and what are potential solutions for this.

So it really has, I think, an action arm tied to it, which I think is a critical component of it and something, when I talk about public health surveillance, is also a critical aspect of public health surveillance. It isn't just monitoring the ways -- someone made a

comment this morning about research sometimes is to just put up a result. But an early warning system is very much tied to an action arm and we want to be thinking about that.

So it's come up previously, but I think it's important to, of course, note with an early warning system, we want to be able to talk about the critical subpopulations within the Medicaid program, children, including those with special needs, adults with acute and chronic health needs, adults and children with disabilities, and the elderly, including those with long-term care needs. So we're going to need signals tied to each of those populations.

This is kind of a pictorial of how we've sort of conceptualized some of the ways of what an early warning system, what kind of the different levels and thinking about both the determinants of access as well as, picking up on some of the conversation this morning, what access ties to getting access to quality services. So we've conceptualized the idea that you could have things, and I'll give examples of this in a moment, of national and State economic indicators, for example, as we know that these are tied to the demand for Medicaid as an insurance coverage mechanism. Federal and State health policies have an impact. The health system structure itself. Characteristics about the individuals who are using the service. And

then ultimately how that access to care affects process and outcomes of care is tied to the IOM definition.

And to provide you with sort of examples of these at the different levels, and these aren't meant to be these are the ones that we will choose, but to sort of help you try to think about the different kinds of measures that one would have at these different levels, at the national and State level, you could have things like unemployment rates that would start to trigger for you, oh, we're going to have an increased demand in the need for Medicaid and CHIP programs. At the Federal and State level, you would have things like, gee, what are the payment rates to providers and how does that impact on the degree to which providers are participating in the program, obviously an important part of providing access to care. Issues about the health system structure, so if you're focused on pregnant women, how many obstetricians are there per population in the different geographic areas. So not even just the ones in Medicaid, but in general, what are the structural availability of different parts of the health care system.

Moving into, then, issues about the individuals, so what are the characteristics of the individual. So, for example, if we're again focusing on obstetrical care, how many women who are pregnant

in the Medicaid program have different educational levels, different capacities to, in fact, be able to utilize services in a way that will help to achieve good outcomes. Process of care -- how many of those women get early prenatal care, and so therefore have a better likelihood. We know early prenatal care is associated with better outcomes, so having good access to prenatal care is going to be important. And ultimately, the outcomes for these women and their babies, things like how many of the babies that were born are very low birth weight or of normal weight and so forth.

So these are the different ways that you can think about some of the measures that could run through those different levels that I shared with you, and each of them could provide signal, and ideally, of course, you want to have signal that ties to the things that you ultimately care about, access to supporting good health outcomes.

What are some of the key characteristics of an early warning system? Well, I think some of these are obvious from some of the definitional issues, but just to highlight them, you would need to have timely measures. This is something that's really quite significantly different in a lot of ways than a lot of the research that's done historically about Medicaid, where there are often

substantial delays in being able to know, gee, we now know from several years ago how Medicaid was functioning. We want much more real-time capacity to be able to, again, make an action that can start to make a difference in how the program is functioning.

Clearly, we need well-tested measures that are reliable and that are valid to be able to make sure that we're confident that we know what we're measuring and that it's about the things that we care about.

Actionable measures, I've touched on.

The variety of access measures that match the different health needs of the different populations that are involved.

We want access measures -- if we're going to use something like the IOM definition, we need measures of access that tie to quality of care, and let me just sort of bring up an example as a distinction that relates to the conversation this morning, that you could take something like a wait time as a measure in access, and you could imagine wait time could be a critical measure if it's tied to a set of services that really have time dependency to them. So things like hospitalizations for things like asthma and diabetes, where there are time windows that the wait may matter, is really important to be able to monitor, whereas other wait time things may be more of

a consumer perspective of, gee, it's not really fun to have to wait for service, but may not be as much tied to a health outcome difference. And so making some distinctions about the access measures and how they tie to important implications in terms of process and outcomes of care, I think is an important way to see it, and, in fact, part of why we thought there was something attractive about the Institute of Medicine definition that seemed to link those concepts together. But something that I think is worthy of further consideration by this group.

I think sampling strategies are going to end up being very important. That came up, obviously, with some of the survey stuff, as well. But ultimately, you need survey sampling strategies that would allow for comparisons across States.

And then, ultimately, a set of dashboard indicators that could trigger in-depth examination to look at causes, local problems, solutions, and so forth.

Important additional considerations, the costs of doing all this. This has come up again this morning and is a critical part of this. As you get into smaller geographic areas, sample size areas go up and the different methods, you know, there are cost implications.

And there are real issues about the acceptability, and

again, I think good comments were made about that this morning, about what is the burden of asking and acquiring information, whether it be from providers, from patients, from State officials, and so forth.

I'm going to turn a little bit to the public health surveillance part of this. What can we learn from public health surveillance as it applies to the Medicaid and CHIP programs? The public health surveillance is rooted in the Center for Disease Control and public health surveillance is for the purposes of ongoing systematic collection and analysis and interpretation of health data. It's been an essential part of planning, implementation, and evaluation of public health practice and it's closely integrated with timely dissemination of these data to those who need to know it. So again, I think a critical concept there is that these data are an important part of being able to run programs and that there are action items tied to the kinds of data that are collected.

If we try to categorize what are the different types of public health surveillance that are done out there, there are essentially six main methods that are used in public health surveillance by the CDC. The four that are bolded there are the four that I think probably have the most relevance for the Medicaid and CHIP programs.

The weaknesses -- a passive provider system, I'll just mention so you understand what it is, is a method where you might have providers aware of things that they might want to sort of submit a note to the CDC or to their State public health officials about a problem that they identify. These, of course, are very "catch as catch can" kinds of things and are not systematic in any way. They're the least expensive, but the least effective in terms of a way to try to collect information.

Active provider systems, in contrast, are systems in which, either based on disease registries or reviews of medical records, that there are teams of individuals who are involved with working with providers to glean information from those providers that could be useful in a surveillance system. So it's a more costly way of doing things, but it's an active and more systematic way of collecting information from providers.

Because that can be quite expensive if you do it on a large scale, it's often been used in combination with sentinel providers, that is, finding certain providers who may be sitting in locations that are critical -- at critical points in the system that really give you insight into the system as a whole. And so using active in combination with sentinel is something that I'll come back to as a

potential mechanism of being able to learn about the system.

Repeated surveys is another method of trying to collect information in an ongoing way, to track things. We learned about some of those surveys this morning. The CDC also has surveys that it does, like the Behavioral Risk Factor Survey that it administers with States is an example of each year tracking information as a way of monitoring what is happening with progress on particular issues.

And then, finally, administrative data mining, the use of claims data and other kinds of administrative data as a way of trying to identify key issues that can trigger and help one be aware of problems in the system.

I'll just touch on briefly Internet monitoring, which is noted here, is probably the newest method that the CDC has started to use some in public health surveillance. This mostly involves the use of searches and Google and things like that as a way to try to learn about whether there's a bunch of chatter around a particular issue that might signal something is going on. And social networking ties into this. This has not been fully sort of captured and developed yet, but is a method that has been talked about by the CDC.

In terms of where we can start, I think the current sources of data that are out there are most visible in the area of surveys

and administrative data mining. You learned about some of those survey things and some of the problems that were highlighted this morning, that national surveys typically have limited information on access questions and State-level data, and you heard a lot about that this morning. Also, the delayed data release is problematic. There are a lot of State-specific surveys that are out there, but this creates real problems for comparison issues across States.

Administrative data mining is something that's quite available, as well. You know, looking at billing and program participation data is a possibility. Some of the issues about encounter data and how robust and accurate and consistent that is, I think is a significant question.

And then other kinds of State data, like we touched on previously, the HEDIS and CAHPS data. Those are really interesting opportunities in managed care. Something that I'll highlight that wasn't touched on previously, though, is that in most States, that is going to -- not in most States, but in many States, the populations that are included in managed care may, in fact, be women and children, and so it may be more likely that you'd be missing out on opportunities to monitor the elderly or disabled populations who are less likely to be in managed care in many States.

I think it would take new investments, but drawing from opportunities and from what public health surveillance has to share with us, there may be ways to enlist providers to get involved in reporting about health care access, and we would want to think about the different levels, whether that's hospitals, emergency departments, clinics, and professional provider groups. And again, the most effective way of doing that kind of surveillance would be active surveillance, not just relying on when a provider thinks it's worthy of submitting indication of a problem but to actually actively pursue this. And probably the most efficient way to do that would be through sentinel providers, key providers who you think may be working in locations where they are most likely to observe potential problems in how the system is functioning.

And I will just close with that by saying that like public health surveillance systems, early warning systems for Medicaid and CHIP would require close collaboration with States, perhaps smaller communities at times, and providers as a way to, in fact, create a robust picture of what's going on in a timely way. I think the most promising strategies are those to think about ways of adopting existing national surveys by potentially adding Medicaid supplements where feasible. Mining administrative and billing data seems like

it could be a very robust area. And then building upon that potentially with active surveillance with sentinel providers. So I'll stop there.

CHAIR ROWLAND: Thank you, Andy.

And now we'll open it up to questions, David first.

VICE CHAIR SUNDWALL: Just a couple. Vern, nice to see you, and the snow is good in Utah already so come on back.

[Laughter.]

VICE CHAIR SUNDWALL: But, anyway, I was curious about -- obviously, you put this together quickly. What is your N? How many people did you survey? Did you do this for every state?

DR. SMITH: Well, the survey is going to every state. We don't yet have a response from every state. We hope to have a very good response rate to report at your next meeting, but at this point in time, I think we've received responses from 10 or 12 states in the very short period of time that it has been out, which is essentially since Thanksgiving.

VICE CHAIR SUNDWALL: I am interested to see what you get, because -- I don't know if I should say this in public. This is the part of our charge I have the most trouble with because I don't think it's needed, and that seems to me as though there's ample opportunity

for us to see stress in the system, under-insurance. I have just, as I've told some of you, received our rankings from the United Health Foundation, which isn't perfect but it's pretty good 22 monitors of public health, that showed we slipped from second to seventh, and I have some real challenges to focus on. But that's not the only survey done. The Trust for America's Health, they have just monitored our preparedness system. We get all sorts of help, nationally and otherwise, on where we're going, where we need to pay attention to. And I realize the system is always in flux and it is -- but we monitor our coverage and our percentage of uninsured quarterly, like you said. So not that I can't use all the help I can get, but it seems to me like we have a lot of real-time or pretty timely indicators.

And I'm really glad, Dr. Bindman, you talked about public health and what we're doing. And in the spirit of not reinventing the wheel on public health indicators, I'd suggest your staff work with ASTHO, the Association of State and Territorial Health Offices, which has a very vigorous public health surveillance group, the state epidemiologists, and they're very smart and very capable, and as you know, we get a lot of data from CDC. And I'm not for a minute suggesting it's perfect, but I'm just wondering what Congress needs that they're not getting, or maybe there are states that are not doing what I think

is common practice. But it's a challenge that we have to fulfill this obligation.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Just a couple of questions, one to Andy. Would it be good for us to add to the list of indicators that you've suggested, something that I would call tectonic shifts? I mean, there are a lot of things that I assume -- actually going to David's point -- set off bells and whistles for any state. For example, you have a hospital closure, you have a plant shutdown, you have a natural disaster. You have huge Medicaid cutbacks, even if it is not eligibility, if it's in services or payments, that are -- sometimes they're all over the state, but often they're quite localized, and I'm wondering whether we ought not to think about adding that so that even if all these other measures that are somewhat more nuanced, that may take time, that some of them can build slowly, or they're kind of always the same. You know, D.C. has had a low birth weight problem forever, but when D.C. General closed, I mean, that was really an alarm system for a whole part of the city.

And, Vern, my question for you was: In the work that you've done so far with the states, thinking about where the HEDIS and CAHPS measures are strong and where they're not, how much are the states

monitoring what I think the data tell us are the most serious problems, which are the subspecialty? This is where, of course, in terms of the access litigation, typically the plaintiffs in access litigation cases are not children looking for check-ups, although sometimes they are. It's typically children or adults with extremely serious medical conditions. And I'm just wondering if we've got sort of a cognitive dissonance problem between the population-based tools used to get a sense of whether your managed care plan is doing a decent job and the kinds of drilldown access problems that often are the real fault lines in the Medicaid program.

DR. SMITH: Very good question, Sara. We're too early to give a definitive response based on the survey, of course, but what we've seen so far is that there are some states that are, I think just looking at it, and primarily through the managed care programs, but also on the fee-for-service side, really trying to look at all aspects, whether it's specialty care or primary care. One state is looking specifically at EPSDT utilization and kind of on a county-by-county basis identifying those that are above the average and below the average, and where it's below, trying to do something about it, you know, taking specific actions. So that is one thing.

But your point about where the access issues are and where

the litigation is, one of the states that responded indicated specifically that its litigation revolved around the elderly and disabled populations, not around the families and children at all. And so that is clearly an issue. You have to look at the whole constellation of those that have Medicaid coverage.

DR. BINDMAN: And just to answer your question, first of all, I love the use of the earthquake analogy. I'm very sensitive to that.

[Laughter.]

DR. BINDMAN: I think you're right and I think it could fit within this structure as well. I mean, a hospital closure is an example of a structural change in the health system, and then you can think about then linking your sentinel providers to those that are in the community where that happens. So I think that's exactly right about how you might want to interact, thinking about, you know, the methods that you have of sentinel providers in association with those structural measures.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I like your breaking down the populations looking at early warning signs for the three different groups that we've talked about because, as you just pointed out,

Vernon, about the lawsuit, it may be very different. And I know that, just to give one example in long-term care, recently in our state none of the nursing homes will accept Medicaid pending, which was a real dramatic shift. So it's things like that that Sara is pointing out, which may be useful. But I think if you don't break it up into populations, you wouldn't have thought about that.

The other comment I would make is I also liked your comment, Andrew, about sentinel providers, and I think one of the key early-warning systems that we have to think about are the safety net providers because they are predominant provider of care to this population, and they will be when the expansion occurs. And I personally think that at least the large urban public safety net hospitals are in very fragile condition. I think many of them are in the ICU right now. And if we really had, you know, not just a D.C. General and an MLK close, but many of the very large urban safety nets either radically downsize or close, that would be tectonic. So I think monitoring those providers in some way is really important.

The last comment I would make -- and maybe it fits more in the previous discussion of access -- is that I do think that specialty care for the acute population is a huge issue, and so is there a way to look at claims data for key procedures like how often

this population actually gets stents compared to the overall population for coronary artery disease? So you could look at sort of a group of procedures that are emergent, urgent, like stents, like laser therapy for diabetic retinopathy, some things like that, and then elective, which I would guess is even harder. So if you looked at, you know, joint replacement, and then some -- and I don't know whether we can get this data from administrative data, but stage of diagnosis of malignancy, which is -- because one of the things we know is getting an oncologist and ongoing oncologic treatment is really tough in this population.

So there may be sort of selected administrative data related to access to certain procedures that would indicate an early warning.

DR. BINDMAN: I think those are good ideas. I'll just throw back to the group to think about as a challenge related to that is just to the extent that you can identify clinical issues, which is, I think, what you're doing, is making sure that these are ones that you feel confident about, are that, A, there's an appropriate rate of getting those things, and that access is what's coming into play as opposed to either personal choices or other kinds of factors.

And so I think there probably are some opportunities in what you're talking about, but I think careful selection would have

to go into that.

COMMISSIONER GABOW: I agree.

COMMISSIONER HENNING: Well, one of the things I just wanted to mention is that sometimes what you need to look at is not just is a hospital closing, but are they closing a particular service, like obstetrics? Obstetric units all over this country have been closed, which means that women have to travel further and further to deliver their babies, assuming they want to deliver in hospitals, which almost all of them do. So that means not only do they have to travel further, but if you're sending them to the hospital because they're in labor, you end up sending them by EMS, which ends up costing the system more money, and it keeps an ambulance out of service that could be taking your heart attack patient that had a heart attack unfortunately five minutes after your labor patient showed up from being able to take that person to the hospital.

So I think that, you know, if you're going to be looking at things like access and, you know, problems as an early-warning system, you also need to be looking at, you know, are we providing the services that our patients need? And even if they have an obstetrical unit, there's sometimes things that they can't get there, like if I have a patient that wants a vaginal birth after cesarian,

she has to travel to either Tampa or Miami, which is a three-and-a-half-hour drive either way. That's the nearest hospital that will allow her to have that service.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: Thanks. I am eagerly looking forward to the feedback we get from the states on what they do. I think there's been a lot of good efforts out there that some decent procurement tools, readiness review type things. I know at least one or two states that have triggers for capping enrollment when certain warning signs go off with health plans.

It strikes me, though, there may be another fertile field we should plow at some point if we think there would be value there -- I think there would -- and that would be the MCOs themselves. They're charged specifically as part of their business operations with making decisions about what is the network capacity of the panel or the groups of docs we've got. How do they ask those decisions? They all have administrative rules or policies on how to monitor the size of their networks, and I'm sure they're scrambling now looking at Medicaid enrollments already growing substantially. But with the law in place and the potential participation in the exchanges or that triggering additional enrollment, they have to be looking at that.

So they might not all agree on how to do that. We might not agree with them. But it might prevent some reinventing of the wheel.

DR. SMITH: If I can just comment on that, some states are doing that now and monitoring the capacity within MCO provider networks with the goal that at least 80 percent of the panels should be open; that is to say, 80 percent of providers are still, you know, willing to take additional patients. That's one example. There would be others.

COMMISSIONER COHEN: Just two quick comments, and thanks for the presentations.

First is just in response to David's comment. I think all of us would be extremely pleased as to the findings from your survey and otherwise suggest that there are great systems in place in most or all states for determining access problems, and we can both report that, dispel a myth perhaps; and, furthermore, if Congress wants it, figure out some systematic way for that to be communicated and sort of kept by CMS. So, I mean, I think that would be a terrific outcome and one with value.

And my second point is just -- and this is a little bit of a question to Lu or others about sort of the derivation of the early-warning system requirements. I had sort of always assumed that

it was part of the legislation, with an eye towards changes in eligibility in 2014 and the possibility that many new populations would be coming through Medicaid and other forms of insurance to be served by a health delivery system that, you know, doesn't have that much time to grow. And so, you know, I just think we should stay focused and make sure that whatever we come up with, at least -- not that that's the only thing that an early-warning system is good for, but we should make sure it is good for that. And also just to be clear, that an early-warning system is one smallish piece of our access work. It inherently is about changes, monitoring changes, and it doesn't suggest that if there's no change what we have is fine; but also I think we need to be careful to keep it sort of focused on changes, whether they're local or broader than that. And our access work obviously needs to look much more at the status quo.

CHAIR ROWLAND: And remember that the statute also ties the early-warning system to supply issues and looking at supply.

Steve first, then Judy.

COMMISSIONER WALDREN: Sure. Just adding my comment, and it's kind of more of a comment for the Commission, too, along the lines of what Andy had just said. When I was thinking about a early-warning system, two things I thought of. One is when Vernon

talked about keeping it anonymous for the states that they don't feel threatened, so that we get good information to make that. But then if it stays that way, then my other point is what are the levers that Congress would have to be able to do something with those things. If it is something that's state-specific, what could they do relative to that? Then I thought about the one issue about the oncology, though. You could do something like they've done with the primary care bonus. You could do that with cardiology.

So I guess when we think about the early-warning system, not only what can we do but what actions can be taken and then focus on making sure that we get that data.

COMMISSIONER MOORE: Vern, I was struck by your comment that states had suggested or said that they would welcome some guidelines or some suggestions as to what they should be doing, and I think this is another thing that many of us have been surprised to start hearing more and more in the last five years, and that is, states asking for additional guidance from the federal level. And I think we could give that guidance as well as CMS, and if it's, you know, a fairly general kind of thing, then I think that's terrific. And I wondered if you had any more to add along that line in terms of what people may have said to you about what they would like.

DR. SMITH: Yes, thanks, Judy. I wish at this point in time we had more to add on that. So far, it's kind of an isolated comment, so we'll see when we get more results if we hear more along that line. Maybe that's something when we do some of the interviews we can follow up on.

CHAIR ROWLAND: Richard.

COMMISSIONER CHAMBERS: Vern, can I just follow up on that? I am curious. Did you get any feedback where, you know, some states would say they're interested in being able to have some standards for an early-warning system? But being realistic, particularly in the current economic environment of states, sometimes I assume Medicaid directors don't want to hear that they have a problem because it is tied to oftentimes it's a cost issue and there is no money to do it.

Coming from a state that routinely over the last three or four years with, you know, $20 billion plus deficits every year, tried to reimbursement rates and just take the chances, to go to court and repeatedly lose in court, for the single reason they don't do an access study and the judge says over and over again it's required by federal statute. But the state sees it as buy six months to a year of, you know, cutting payments until they have to retroactively go back in

the next budget cycle to pay back the cuts in the previous year.

Any trepidation that as, you know -- yeah, sure, it would be great to have an early-warning system, but how am I going to actually live within the requirements of suddenly having measures that the feds could say you're out of compliance with access?

DR. SMITH: Well, Richard.

[Laughter.]

DR. SMITH: You have put your finger on a real issue, and I think -- I'm not thinking of a -- well, one state I'm thinking of a response that was like that, maybe in a more informal response, but it's kind of hard for states to articulate this because there is concern, and there is concern about how specific the access standards are right now. And, in fact, there is some concern that they're maybe not clearly defined, but there is concern that there would be a fiscal issue if it's measured and that a state might be compelled to raise its rates, for example, which is one of the remedies.

So in these times of kind of extreme fiscal stress for the states, I think it's a real sensitive issue.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I'm actually intrigued by this

approach to sort of link back to public health, and I might keep forever Slides 7 and 8 because I think it actually addresses some of the concerns that Vern raises. So this may have use for us in our access discussion because if you looked at the blocks of the different levels, it strikes me that you've got a comprehensive view. You're starting to look at health status, but access matters around status of health. You begin to look around federal and state health policy. You could add local policy as well to get at the issues of changing service delivery systems. You could even add into that a comparative analysis of FMAP rates and tax burden in the states and to really help states so it doesn't feel as pointed that this is all about provider rates. It's a bigger issue and it helps us identify that.

I'd also be a little more sanguine about whether the notion that states want federal guidance will continue, and we have to remember that many of these Medicaid directors will change or they'll stay as their bosses change, and there's certainly much more chatter in the last month about state flexibility than I've heard in the last six years. So I think we ought to just wait a bit before we make any assessments, and we'll look to Vern's wonderful work to figure out what the states are saying as time goes on.

DR. BINDMAN: I just want to make one response because you

brought up the public health surveillance mentality again. In thinking a little bit about your comment as well, Dr. Sundwall, the CDC's method of doing public health surveillance isn't a static thing. It actually evolves over time. And in fact, if you look back over the history of it, it goes back a very long time. It started in Rhode Island as kind of a contagious disease monitoring system, and each year there is sort of a revisiting among the state epidemiologists about what are the important new diseases to think about.

In fact, one big change that's happened is they've evolved from just thinking about infectious diseases more toward chronic disease, as we recognized the population has changed.

So I think it is a very useful footprint to build upon, but part of it is also the evolutionary nature of it and how it can be responsive to the different kinds of policy issues that could come up with Medicaid and CHIP over time.

COMMISSIONER COHEN: Can I just add this? I can't help it. Don't forget about there are, at least in some big cities, large local health departments. They don't have routine involvement with Medicaid, and so you really need to sort of keep that piece in mind. They cover a lot of population.

VICE CHAIR SUNDWALL: Just one follow-up comment on that.

There has never been a better opportunity to help marry or merge or integrate public health and Medicare and Medicaid than right now with Dr. Berwick because he clearly has a public health sense and approach to paying for health care, and I appreciate his attitude. And I think we as MACPAC ought to be aware of that and to the extent we can kind of foster that thinking.

CHAIR ROWLAND: And clearly, we're learning that everything we're doing weaves together, so what managed care plans do and how they assess the adequacy, our definition of access, but even getting back to the data and that data collected ought to be data used. And I think one of the things about the public health surveillance system is that it has a timeliness and it has an outcome that, when action is needed, they take it. And I think one of the challenges in our review of an early-warning system is, okay, if you identify the indicators for the early-warning system, then what do you do about it when you trigger those indicators?

So this is the beginning of what I think is a very, very important and integrating discussion for the Commission, and I look forward, Vern, to all 50 states responding to your survey, as they usually do, and, Andy, to continuing to work with us on this issue and on the broader access issues generally. So I thank you very much

for starting our discussion today.

And next we will move on to another issue of coordination of care and one that weaves a lot of other things together as well as weaves us together with MedPAC, which is also looking at this issue, and that's really the issues around the dual-eligible population, around their access to care and around ways to develop a more coordinated approach.

I'd like to welcome to our discussion Christie Peters from the MACPAC staff along with Chuck Milligan, the executive director of the Hilltop Institute and someone with vast experience with the Medicaid program itself, and Trish Nemore, a senior policy attorney at the Center for Medicare Advocacy, again, with vast experience on the beneficiary side of this equation. So we are really interested in you sharing your views about some of the issues, obstacles, and opportunities as we go forward to look at the dual-eligible population.

I think Trish is going to kick it off, right? Thanks.

ISSUES IN COORDINATING CARE FOR DUAL ELIGIBLES

BENEFICIARY PERSPECTIVES

MS. NEMORE: Thank you, Diane, and thank you for this opportunity to speak on behalf of dually eligible beneficiaries.

There's very little time, and I think the message that I would want to leave with you more than anything else is that we are now in an environment of a lot of discussion about full integration, Medicare, Medicaid money together, long-term care, acute care together, new systems, new models. There is much to be done in the here and now to help duals have better access to health care now. We are long way from those perfect systems. We have a lot of disagreement about those systems, and even if we didn't, we'd have to build them.

There are a lot of things that can be done now. Some of them are administrative. Some of them are for Congress. And I hope you will just see this as an opportunity to be looking about how, before we get to the perfect, we can make life better for dual eligibles.

I want to start with two stories that really illustrate some of the on-the-ground access issues. The first is the story of Narcisa Garcia, who is a named plaintiff in a class action lawsuit that was brought in April of 2009 and settled in April of 2010. She's 66 years old, has a very small Title 2 benefit, just above the SSI level, 77 percent of poverty, $695 a month. She moved from Florida in October of 2008. Florida had her on Medicaid and was paying her Part B premium. She got to Pennsylvania, went to the welfare

department, told Social Security as she was leaving Florida that she was leaving, went to the welfare department in Pennsylvania, applied for Medicaid, got a notice in November saying, "You've been approved for Medicaid. We will pay your Part B premium." In January of 2009, she got a Title 2 check for $406.20. That's 45 percent of the federal poverty level. Think about living on $406.20 a month.

She got a notice from SSA saying Florida Medicaid has stopped paying your Part B premium. She already had a notice from Pennsylvania saying it was going to pay her Part B premium. In February, she got another check for $406.20. In March and April, her checks were $599. She went to the SSA office twice to work this out. They told her to go to the state. She went to the state office three times to work this out. They told her to go to SSA. We filed suit in April of 2009 and settled the case with Pennsylvania in 2010 in a way that will benefit a lot of people like Mrs. Garcia.

The second story is one of a client represented by a New York disability advocacy organization who needed liposuction for a buffalo hump, which is a fatty accumulation at the neck and upper back that's common to people with HIV. This was a dually eligible person. Medicare said, "Maybe we'll cover it, but only if it's medically necessary, and we won't determine that until after the

surgery is done." No surgeon would do the surgery without guarantee of payment. A dual-eligible cannot pay for a surgery up front. Medicaid refused to provisionally approve the coverage, said they would only pay if Medicare denied coverage and if Medicaid then determined that the procedure was medically necessary.

Again, this is a common situation. It happens more commonly with durable medical equipment. We hear all the time from states. People needing complex wheelchairs run into this. Medicaid won't approve. Medicare requires you to get the service and get a denial before you can even get into the Medicare appeal system. Medicaid won't pay because of third-party liability issues until you do that. And so people are at a standstill. Some states have done pretty good jobs of addressing this in a somewhat clumsy way, but a way that works for people. And I think there are ways that we could help other states do that.

Just as a matter of looking at how Medicare and Medicaid pay for -- or look at coverage issues, Title 18 focuses on diagnosis and treatment of illness and injury, and Medicaid focuses on attaining or retaining capability for independence and self-care. Those are two very different kind of statements of what they're about. You have to get skills services in Medicare to get home health or skilled

nursing facility care, and you don't in Medicaid. So there's a very different orientation of the two programs, and that does show up in coverage, even though there is, of course, huge variability throughout the states.

When I talk about barriers to access to benefits, I'm really talking about getting eligible for the program, getting into a Medicare savings program to help pay your Medicare cost sharing, getting into the low-income subsidy to pay your Part D cost sharing. The issues about access to these benefits have been studied and studied and studied for decades. There's just a very, very long list of excellent reports that have been done for the last 20 years documenting some of these barriers. We are making a little inroad on some of them, not so much on others.

I really want to focus a little bit on this slide because I think it is where a lot of the issues are that could be addressed -- not necessarily easily but could be addressed -- that affect dual eligibles. The way we implement third-party liability in most states is requiring what was required in the liposuction. You have to get a Medicare denial before Medicaid will agree to pay. There is not a system automatically for Medicaid to say, "We'll cover this if Medicare doesn't." There's no reason why there shouldn't be such a

system, but CMS and the states have interpreted third-party liability to really require the states to put this obstacle in people's way before they can get services, and it makes it very difficult. There are states where it's done differently, and it works much better for the beneficiary. It's a much more seamless program. It is worked out behind the scenes between Medicare and Medicaid rather than on the front line where people are trying to get services.

Reimbursement has been an issue particularly with the Qualified Medicare Beneficiary program, which pays for Medicare cost sharing for people with incomes under 100 percent of poverty. From the time the program was passed in 1988, states were supposed to pay at the Medicare level, so Medicare -- we'll talk about a doctor's office visit. Medicare would pay 80 percent of that, and the state was supposed to pay 20 percent. The BBA of 1997 said states could pay at a lesser rate if their Medicaid rate was less than that full 20 percent, including nothing at all if their Medicaid rate was below what the 80 percent Medicare payment was. And, in fact, we know that at least 30-some states do that. I don't think we know how many states do it because I don't think anybody has looked at that issue, and that is a data hole that we have.

In 2003, the Secretary sent a required report to Congress

looking at the access issues that were caused by this BBA provision that allowed the states to pay at the lower rate. The study looked at maybe five or six states and looked at two services: doctors' services and mental health services. They found access issues related to the reductions. They said, "This was a very narrow study. We need to go broader. We need to go deeper. We need to know more about this, and we don't know how it ultimately affects the beneficiary." And nothing has happened since that study was done, so definitely there's another data point that we need to look at.

The Qualified Medicare Beneficiary program is a wonderful program that is completely not understood by anybody, not by the providers, not by the states, not by the feds, not by the beneficiary. It doesn't just pay premiums. It pays all the cost sharing. But there are no systems to make that work. CMS has put out guidance over the years, significant guidance saying you can't bill the beneficiary, it is illegal to bill the beneficiary, you have to submit to the state for the payment. If it's just a Medicare-only provider, the states may not have a system for people to be able to submit a claim. The providers may not know about the system if it does exist. The providers don't know that they're not allowed to bill the beneficiaries, so beneficiaries get bills over and over again from

providers. We've made a tiny inroad on working on that, and there's a lot more that could be done to make that benefit viable. But there is the issue of the payment rate, which will always be a factor, but it's not the only factor, and there are other things that can be done there.

Differing coverage standards. There's lots to say about this, but really the liposuction case is an indication of that, is an example of that, and I'd be happy to talk in further detail about that.

Medicare Advantage special needs plans are kind of the newest hoped-for solution for dual eligibles, but we know that there are issues of provider networks. There are cost-sharing protections that aren't done. And that's true in the traditional Medicare sector as well as in managed care. So I think a lot of the things I'm talking about, they don't distinguished between managed care and traditional Medicare. So if we don't address them, whatever systems we develop, there's still going to be problems. And we're pretty sure that most plans don't give people much help getting their Medicaid benefits, and we don't have much evidence of added value.

There are a lot of data issues that I'm happy to talk about in more detail, but from now I just want to look at the four data-sharing

systems. One of the key ways we resolved the case for Mrs. Garcia in Pennsylvania was to get the state to agree to share data on a daily basis with CMS. It's 2010. With LIS, with the low-income subsidy, there is data sharing on minute by minute. It's all real-time data. And even there we have issues. But Pennsylvania was submitting data once a month. CMS was sending it back once a month. If there was any error in it, it was months and months before it would ever get resolved. So the idea that we don't have a requirement for daily data sharing is just a bit shocking.

We think there are a lot of things that can be done that are actually relatively simple. Some of them may be less simple because they cost a lot of money. But we've made some inroads in increasing funding for information counseling and assistance. These programs are so complicated, and we really need -- there's a lot that can be done through data, but we need a lot of one-on-one assistance. We just do.

Authorize the IRS and SSA to share data would allow for a targeting of outreach for the low-income beneficiary population to get them into the LIS and the MSP program. We've been working on aligning MSP and LIS. We're much closer than we used to be, but they're not fully aligned. So while MSP gets you LIS automatically, LIS does

not get you MSP automatically. We need to simplify our state Medicaid eligibility systems and recertification systems certainly where we lose a lot of people that we've worked very hard to get into the program. We lose them at the recertification level.

We've worked on eliminating the asset test. The Affordable Care Act eliminated it for everybody else, but not for dual eligibles. We need to stabilize -- we just got the QI reauthorized for one more year, but it really should be folded into a single QMB benefit, just sort of comparable to LIS.

There are other points on here, but I see our time is running out, so I am more than happy to discuss any of these things during the question period. And I hope that you will maintain contact with the Center for Medicare Advocacy. We're happy to work with you.

Thank you.

CHAIR ROWLAND: Thank you.

Chuck? I know there were lots of acronyms there, too, so when we enter into the --

[Inaudible comment/laughter.]

MS. NEMORE: I wanted to say that there are a few on the Commission who are more familiar with these others than maybe some other people, and I hope you will fill in the longhand for a lot of

the shorthand that I used.

CHAIR ROWLAND: The next discussion we have, we'll go through the fact that the dual-eligible population has various layers, and there's full duals and there's some that only get help with some parts of their premiums, and some that get cost sharing plus premiums. So we'll go over all of that at a future meeting.

CASE STUDY: THE EFFECTS OF PROVIDING MEDICAID LTSS ON MEDICARE ACUTE CARE RESOURCE USE IN MARYLAND

MR. MILLIGAN: Well, thank you for the invitation. Every time I hear Trish, I feel like I should not speak and just run out the door and go fix something.

[Laughter.]

MR. MILLIGAN: I want to just let you know that my task here is to wow you with some data, so I'm going to try to do that.

I work at the Hilltop Institute at UMBC. We do a lot of work in Maryland. We have Medicaid claims for all the Medicaid beneficiaries, Medicare claims for all the duals. We have MDS records for all of the nursing facility residents regardless of payer, and we have combined all of those at the individual level. So, among other things, we can look at the effect of Medicaid payment on Medicare service use, Medicare service use on Medicaid. We can look at lengths

of stay across time by linking one NF stay to a hospital back to a different NF stay. We can look at the differences in Medicaid use for somebody in Medicare Advantage versus Medicare fee-for-service. We can look at nursing facilities that do a better job. We can look at money follows a person, deinstitutionalization into the community, and whether it's stable, whether those people go to the hospital. I'm not going to present any of that today.

What I want to present to you today -- I'm sorry.

[Laughter.]

MR. MILLIGAN: I'm going to present a case study, and it's a case study where we looked very specifically at the largest nursing facility, home and community-based waiver in Maryland, which is known as the older adult waiver, which had about 1,800 beneficiaries in 2006, which is the data I'm going to present. And what we did is we compared that group against two populations. We compared it against duals. So I'm going to focus on those duals in the older adult waiver and compare them to duals in the community who are not in the waiver, and I'm going to compare them to duals who are in institutions.

What we did is we did this comparison by using a propensity score methodology, which was done by individuals at Hilltop much smarter than me who understand how to do fancy things, as well as

mathematicians at the faculty. Dr. Tony Tucker was the lead investigator on this. But what we did is we did some matching. We took the 1,800 older adult waiver beneficiaries, compared them to the 19,000 duals in the community who are not in the waiver against all of these criteria: demographics, their CMS HCC relative value, which is their Medicare risk adjustment score; 20 chronic condition warehouse conditions; disability as the reason for Medicare; frailty indicators using the Johns Hopkins ACG risk adjustment system; ESRD indicators; and also Medicaid.

So what we did is we tried to create pairs. We wanted to create apples-to-apples comparisons, so we took those 1,800 older adult waiver beneficiaries and tried to find a matching person, dual, in the community who matched on all these criteria, and then we took the 1,800 older adult waiver beneficiaries and tried to find a matching dual in the institution. I'm going to present the results.

The home and community-based waiver, the older adult waiver, compared to those duals in the community who were not in the waiver, there were 1,410 pairs -- 1,410 in each of these groups, 1,410 people in the waiver, 1,410 people in the community, not in the waiver, who met all of those acuity, frailty, demographic characteristics. The next three slides focus on that population.

The first slide is looking at their Medicare payments and Medicare service use, and what you can see in this slide is the Medicare dollars were roughly the same. The older adult waiver group, the home and community-based waiver group, spent about $1,216 per member per month to Medicare and about $1,231 per member per month in the community group. But there were some extremely important differences, and there are some extra slides I won't get to today that are in the materials available to you. But the older adult waiver beneficiaries had fewer Medicare readmissions; they had fewer SNF admissions out of hospitals; their lengths of stay were shorter in SNFs; and they were discharged quicker to the community if they were in the older adult waiver.

In terms of other Medicare services, the older adult waiver group used -- there were more users of Medicare home health; there were more users of Medicare hospice; there were more users of Medicare DME. Ninety-nine percent of the older adult waiver individuals had a Medicare-paid physician visit in the year; whereas, 95 percent of the community group not in the waiver had a Medicare physician visit. And so there was more expense to Medicare if you were in a waiver to home health, hospice, DME, and physician.

The community group spent more in the emergency room, and

when they were admitted to the hospital from the emergency room, there were longer lengths of stay and more readmissions.

So the total dollars to Medicare were about the same, but the Medicare service use was much better in terms of how the services were used when somebody was in the Medicaid home and community-based waiver.

Looking next at Medicaid expenditures for these two comparisons, if somebody was in the waiver, they spent more, not surprisingly, because of the waiver services. So that's the big blue line in terms of the community services and support, sort of in the middle of that picture, and that was waiver-related. So Medicaid spent more than the community group of equal acuity and frailty who are not in the waiver. This may mean that the individuals not in the waiver were getting more informal supports. It may mean that they were getting unmet need. But they were certainly using less Medicaid.

If you combine the two -- so this slide is the aggregate -- somebody in the older adult waiver costs more when you combine the two payers because of the fact that Medicare expenditures were about the same in aggregate and Medicaid waiver costs were higher in the waiver. And when you added them, the waiver recipients cost more.

I usually conclude my presentation by saying, "Therefore, waivers are not cost-effective." But I go on.

[Laughter.]

MR. MILLIGAN: So the next three slides are comparing the matched group of the older adult waiver against nursing facility duals. There were 1,731 pairs here, more pairs because by definition these people were nursing facility level of care; whereas, in the community a lot of the duals were so-called well duals or perhaps healthy duals, whatever your vocabulary is. But there were more pairs in the nursing facility group.

If you look at Medicare -- and this is my favorite slide of the whole presentation -- Medicare spent less if somebody was in the institution than if they were in the waiver. Medicare spent $441 per member per month less if somebody was in a nursing facility, and this to me is -- the quiet secret of dual eligibles is that Medicare has an institutional bias because if somebody is in a long-term custodial Medicaid-paid nursing facility stay, Medicaid generally keeps them well supported. They tend not to go to the hospital as often. They tend not to go to the doctor as often. And Medicare, it's cost-effective to Medicare as a stand-alone payer if somebody is in a long-term Medicaid-paid custodial stay as opposed to being

out in the community where they're going to go see the doctor more often, and higher incidence of hospitalizations.

To me -- I will say this one brief thing -- one hypothesis from all of this is in Medicare Advantage, if you've got a dual in a nursing facility in a long-term Medicaid-paid custodial stay, that's a profit center because Medicaid is basically providing the supports and Medicare is saving the funds.

The next slide is the Medicaid dollars for this population and, not surprisingly, Medicaid spends more because nursing facilities are not cheap. And so even though the older adult waiver costs are significant, the nursing facility costs are far more significant to the tune of over $2,000 per month. When you combine the two, the waiver is cheaper because Medicaid nursing facility costs are expensive.

So some conclusions. The first conclusion is in total dollars the waiver group is far more expensive than the community group and far less expensive than the nursing facility group. So the older adult waiver is cost-effective if you are, in fact, avoiding an institutional stay for somebody who's in the waiver. But it's not cost-effective to Medicare for somebody to be in the older adult waiver in the community because Medicare saves money when somebody is in

an institution; whereas, more or less for Medicare it's a wash. If they're in the community control group, the community group, the non-waiver or in the waiver, to Medicare it's more or less a wash. But Medicare saves money in the institution.

Key observations and findings from all of this. The first is Medicare and Medicaid financing do not align to promote home and community-based services, and this is a barrier to HCBS because Medicare saves money when somebody's in an institution, and a Medicare Advantage plan, which is paid on the basis of HCC risk adjustment, saves money if Medicaid is supporting the custodial stay.

The second finding and observation from this is that Medicaid's HCBS program promotes better service use in Medicare. When somebody's in the waiver in the community as opposed to a dual in the community not in the waiver, they get better access to physicians, DME, home health, hospice, fewer readmissions, fewer SNF admissions, shorter SNF lengths of stay. Medicaid waivers do a better job for Medicare service use.

The third observation is that because most extended nursing facility admissions begin as a Medicare stay, about 57 percent -- we looked at 95,000 nursing facility admissions over a ten-year period of time, and about 57 percent began as Medicare. Many converted

eventually to Medicaid. But because most admissions to a nursing facility began as a Medicare post acute SNF stay, 57 percent, you have got to engage Medicare to succeed with Medicaid community-based integration.

The final finding -- and I'll highlight this --is if you're looking at it from a state point of view alone in terms of Medicaid expenditure, the waiver is only cost-effective if you're truly avoiding a nursing facility stay, because the community group uses less money than the waiver group, and it may be because they have unmet needs, and it may be because they're getting informal supports, and it may be because of both of those things. But from a pure cost-effectiveness point of view, to Medicaid as a stand-alone payer, the waiver is cost-effective only if you are avoiding really a nursing facility admission that Medicaid would be paying for.

I have a lot of data slides to follow, but if people have questions -- I'm not going to get into that. Thank you very much for your attention.

CHAIR ROWLAND: Thank you, Chuck.

Christie?

COMMISSIONER COHEN: Can I ask one clarification question before Christie goes? Is that okay? What did the waiver do? In other

words, what was the difference for somebody who was in the community not in the waiver and somebody who was in the community in the waiver? Should I wait until this is over?

CHAIR ROWLAND: No, that's fine.

MR. MILLIGAN: The waiver provides a series of non-medical social supports that are not otherwise available in the Medicaid state plan, including attendant care, homemaker services, case management, and other services that help provide connectivity to other services and connectivity to care.

COMMISSIONER COHEN: Great, thank you.

MR. MILLIGAN: Sure.

CHAIR ROWLAND: Watch the coffee cup.

MACPAC WORK PLAN

MS. PETERS: Okay, I'll be brief. At our October meeting, when we were talking about the dual eligible beneficiaries, you all talked about wanting to acquire more information about the dual eligibles and sub-populations. In particular, you're interested in looking at the under-65 disabled population. You mentioned you were interested in looking at folks who have mental health conditions or particularly the severely mentally ill, behavioral health cognitive impairments.

There was also talk about possibly looking at pre-duals, trying to define a population that is likely to enter into the dual-dual category. So based on that discussion and what you just heard today, I would like to walk you through some proposed components of the analytic work plan on dual eligibles.

Basically, what I'd like to do is highlight some proposed data analysis regarding characteristics of the dual eligible population and issues for care coordination. At the end, I'll also give you a quick update on MedPAC and CMS activities regarding dual eligibles since these are priorities for them as well.

So basically what we'd like to do is to pursue data analysis to get a better understanding of how do eligible beneficiaries access health care services between Medicaid and Medicare, what services they are getting, and basically how much. Using CMS combined Medicaid and Medicare data at the beneficiary level, we propose to look at enrollment in service use and expenditures by beneficiary, the dual eligible group as a whole, and then also by subgroup both nationally and by state.

We'd also like to look at expenditures and utilization by services, again, nationally and by state. In addition, we would like to look into developing basically a specific population profile, and

in particular, what we were looking at is sort of the method for a person to become dual eligible.

What is the difference between a Medicare person who is spending down onto Medicaid versus a Medicaid person aging on to Medicare, or a Medicaid person qualifying for SSDI and therefore getting their Medicare as well.

So in our efforts to better explain this population, the diversity, and their needs, we'd like to look into this notion of how a profile based on different criteria than just the subgroups we identified earlier might help explain that.

Once we have the state level analysis, we'd like to look at issues and challenges to coordinated care at the state level. We propose identifying states for further review based on certain criteria such as Medicaid and Medicare service use, both overall and for certain services such as SNF, nursing facility care, home health, hospice, home/community based services, and hospital inpatient care.

We'd then like to look at opportunities within the states for care coordination, particularly in acute care settings going into long-term care settings. We'd like to look at state and federal policies that can encourage such coordination, or it can hinder such coordination. So if there is the presence of a home/community based

waiver, or a managed long-term care, how is that creating new avenues for access, better access to coordinated care basically.

Then, of course, we'd be interested in looking at the impact on beneficiary access to coordinated care, and also the expenditures. So these two pieces, the characteristics and looking at care coordination issues, are broad analytic components that we'd like to start immediately.

Another interest you expressed in October was looking at specific statutory or regulatory barriers to care coordination for possible future examination and even recommendations. Melanie Bella from CMS came and mentioned this list that she's making of misalignments, and basically you all said to her, we would love some input from you on one or two or three of the major regulatory or statutory barriers that they would like input from MACPAC on. That list is in the process of being created. I expect it -- I expect to hear from Melanie rather soon, actually, on some ideas on that front.

But some ideas that we also wanted to just put out there for you to consider is the issues that Trish raised regarding the state Medicaid payment of Medicare cost-sharing on Medicaid rates. This does create concerns regarding access. It is a long-standing issue. It has significant financial implications that need changes

to it, but it has not been studied in terms of beneficiary access to providers in a robust way. There was a study that looked at it in just nine states awhile ago, so it is something that I think is worth considering.

The other issue is the asset test that is maintained in 2014 and beyond for the elderly and for the disabled. In a health care reform context, you will have people coming in under the expansion enrollment group who, if they qualify for Medicare because they become dual eligible, they will lose their Medicaid under that expansion avenue.

In order for them to qualify as a low-income disabled person for Medicaid or a low-income elderly person for Medicaid, they have to meet the asset test. So nobody knows how big of a problem this is, but it may be something the Commission might be interested in exploring.

Briefly, let me just tell you that a little bit about MedPAC and CMS activities. For their November meeting, MedPAC staff presented findings from state site visits and interviews with states and stakeholders about care coordination programs. These findings are the basis for a chapter in their June report. The Commission is continuing its work on care coordination programs.

CMS, in addition to its work on the program alignment list, is working on getting states access to Medicare fee-for-service and Part D drug data. The expected time frame for that is early 2011. They are also working with states on establishing shared savings incentives for the new Medicaid health homes because they don't want dual eligibles to be excluded from those scenarios.

Lastly, I want to mention, in terms of MACPAC consulting and coordinating with MedPAC and CMS, this month we are starting our standing telephone conversations between Lu, Mark Miller, and Melanie to help keep information flowing and input as well between the three organizations as they move forward on these issues.

So I'm happy to answer any questions and, more importantly, I'm looking forward to your feedback regarding the start of this analytic work and the specific challenges to coordination of care that you might be interested in examining further, and any other care coordination issues you might want staff to look at. Thank you.

CHAIR ROWLAND: Richard?

COMMISSIONER CHAMBERS: Sure. Thanks to the panel and to Christie. Great information. I think the work plan is good. I think it's one of the things that came already, is folks making sure they understand that it's how dual eligibles are different depending on

their sort of eligibility category, just cost-sharing or full care on the Medicaid side, and I think it's going to be really critical going forward is making sure, particularly for us as the Medicaid commission, is what is the most important, the biggest, highest impact to concentrate on in going forward.

I think the data merge is critical. We've tried that for years at the local level. Since the plan that I'm in charge of has a mandatory enrollment of about 65,000 dual eligibles, and not having any information on their Medicare services because the vast majority are in fee-for-service, is very difficult, as you just sort of inherit the dual eligible after they've blown through everything in Medicare and it would really be good as to be able to have data. I think just understanding the data merge across the programs would be really good.

I think as the consultation and coordination with MedPAC and CMS has been really critical because I sort of see everybody going -- attacking the issue from their perspective, and I think it will be much more effective going across all of these efforts and working together.

Just a couple questions I had for Trish and for Chuck. Chuck, it's a question for you is, do you think, is there anything unique about Maryland in your studies that you think your results

would not transfer to other states' experience for the same population? I just don't know if there's anything specific about Maryland and your Medicaid program.

MR. MILLIGAN: Let me answer that. I also want to sort of reinforce something that Christie said. I think the main -- the areas of state variation include payment policy in terms of the extent to which Medicaid payment, the crossover claim issue that Trish mentioned, as well as Medicaid payment levels for all of the services that were in the data I presented, you know, nursing facility and all the rest of it, the waiver and the waiver composition. Waivers vary a lot state to state.

I think the analytic framework translates quite well and the code that we've written to do the merge and the analysis, I think, would translate quite well. I want to just really, really briefly amplify something that Christie said.

We did look and we looked at all of the 2006 data and there were about 80,000 dual eligibles for the full year, of which 45 percent were under age 65. That's significant. And we looked also in 2007 at the new duals who are not part of 2006 that came into the program, new duals in 2007, and over 50 percent were under age 65.

So I do want to reinforce that the pathways and the

composition of disability as opposed to just poverty as a basis for Medicaid is growing over time. The one last thing is that we have now received two more years of Medicare data that we're updating. There had been a delay on the CMS side of releasing Medicare data to states, as well as Part D data. So we're in the process now of integrating all of the above. So it is available out there to states now.

CHAIR ROWLAND: Richard, in some of the work that we've done at Kaiser, there's a very different picture if you look at the Medicare savings for someone who goes into the nursing home. We're seeing much higher hospital readmission rates among individuals for whom -- they're not all dual eligibles.

But Medicare beneficiaries discharged to a SNF and then on to a long-term care facility often rotate much more rapidly through the hospital and therefore incur higher Medicare expenses because of their readmission rates. So I think that's something worth looking at, and perhaps Maryland has a better system for doing that than some of the other states. But MCBS data does show a fairly high churning for people who end up in the nursing home.

VICE CHAIR SUNDWALL: I just have a really quick question. You talked about the tiers or layers of eligibility for the duals.

Is that simplified in the ACA like it is in general for Medicare/Medicaid eligibility?

MS. NEMORE: No.

VICE CHAIR SUNDWALL: It's not addressed?

MS. PETERS: If you've saved your materials, or I can certainly send it to you --

VICE CHAIR SUNDWALL: Have I read them? Yes.

MS. PETERS: There is a very nice chart that shows how they stack up on top of each other by income and what are the benefits that they receive.

MS. NEMORE: Could I comment on that? Christie made reference to the disconnect between the ACA, everyone else, and the duals and it's pretty significant because it is pretty dramatic. There was this effort to simplify and allow people to move pretty easily from private insurance to the exchange to Medicaid, and we have these very complicated, multi, multi-layer systems that are just sitting there with a completely different set of eligibility rules than will apply to everyone else.

COMMISSIONER CHECKETT: One area that I'm interested in learning more about, there are a handful of special needs plans for dual eligibles wherein the individuals are enrolled in a single health

plan that has a capitated rate for Medicare and a capitated rate for Medicaid, and there's not very many of them because there may be a lot of SNPs for duals, but a lot of times it's just the Medicare benefit.

I would be interested in finding out how many of those plans are, what their enrollment is, and then the real question is, can we, at some point, start to look at the same things that Chuck has talked about with his analysis, but asking those same questions. Because to me, when I look at that population, that plan, that's like everything we've been working toward -- right? I mean, we've got dual eligibles, we've got managed care, the sickest people, the most expensive people, you know, all this stuff added together, and I'd really like to know, is that a better model or not? Because if it is, that would be something of great importance.

CHAIR ROWLAND: Judy?

COMMISSIONER MOORE: This area of service cost and service delivery and service coordination is what usually comes to mind when you start talking about dual eligibles. But I want to go back to Trish's points about the eligibility and enrollment processes.

Because there's been such a heavy emphasis on that since CHIP passed for moms and kids in most states and across the nation and federally lots of push, but the other side of the population,

one of the other Medicaid populations has been completely ignored, as far as I'm concerned, by foundations, by states, because partly of the push for the other.

You've got a long list, however, of things that would address these concerns. Can you kind of prioritize, now or later, for us where you would see the most important things to start with if we're going to address those enrollment and eligibility issues and sort of get the process of getting the elderly and disabled and duals into the system before we try to coordinate their care?

MS. NEMORE: Thank you, Judy. One of the things that we've tried to get attention to for years, because that whole emphasis in the Medicaid and CHIP program, is that we pick up what has been so successful in some of those strategies, and there's just never been the energy around this population.

One of the things that I did not mention, there are a half a million people who are mostly in Medicaid, maybe all in Medicaid, who don't have Medicare Part A. There's no reason why it is not very simple to enroll those people, but in fact, it is not very simple to enroll those people. It's wildly complicated and ridiculously complicated, and it's really a solvable problem. It was also addressed in our case in Pennsylvania.

Those are very, very poor people. If they don't have Medicare Part A, it's because they don't have the earnings record to get premium-free Part A and they certainly can't afford to purchase it.

So that's one group of people that would benefit, and you can create systems to do that that you don't have to go out and find each person. You mostly have them in your Medicaid rolls. You have to find them. There are pieces of it that are Social Security, pieces of it, there are pieces of it that are the state's piece. But that can certainly be done.

Circling back to the asset test, that was one of the things in CHIP that made it easier. Every state, as far as I know, got rid of an asset test for its CHIP program and that eases enrollment. There are -- just not meeting the asset test is one issue. A lot of people think that telling you about my assets is none of your business, and so I'll just forego the benefit.

Providing the documentation of what the assets are can be a problem. So that creates a very significant barrier, and there are nine states that have, by virtue of the provision in Medicaid, that allows them to do that. They've eliminated the asset test. But that's a very significant barrier.

And I think we've gotten a little more money into state programs to allow for the one-on-one kind of outreach and enrollment assistance, and getting greater alignment to allow a much easier whatever door you go in it's going to get you what you need kind of thing.

There were a significant number of misalignments between the Medicare savings program run by the states, which pays Medicare cost-sharing in A, B, and C, and the low-income subsidy in Part D. The Kaiser Family Foundation gave us some support to look at those when the program first went into effect in 2006, and we've made good inroads on getting those closer together, but they're not there yet.

And so, I think Social Security has done a pretty good job of making their system for the low-income subsidy much more user friendly than many of the states are. But if you get through the state system, you'll get the low-income subsidy, but if you get through the low-income subsidy system, it doesn't get you the Medicare savings program. So those are, I think, the places to emphasize.

COMMISSIONER CHAMBERS: Could I just follow up on that? The issue about enrolling in the Part A, for the folks, is that I was told a few years ago by a former state Medicaid director that their state had actually done the economic analysis and it was actually

cheaper to leave the person without Part A because the state's hospital reimbursement was cheaper than paying the penalty for the enrollment in Part A.

So, I mean, that's just a challenge to overcome, is that some states just may make an economic decision that it's better to -- from a state financing perspective as opposed to a beneficiary perspective, that's just something, I guess, we'd have to deal with. Is that a good thing or not? Should states have the flexibility to be able to determine whether they want to do that or not?

MS. NEMORE: I believe that New York made that determination decades ago when the program first went into effect and they have actually reversed that and chosen -- it has to do with having a buy-in agreement with the state for Part A that's what allows the enrollment to go more smoothly, although it's still cumbersome.

I think that the Congress and CMS might tell you that that's not really an option for the states, but nobody has ever enforced it. So, in fact, it is an option for the states, and they're not required to have a Part A buy-in agreement, which is a systems thing that allows it to work better.

I think they are required to pay the Part A premium. So by not having an easy system, it doesn't happen. It just doesn't

happen. They're required to do it.

COMMISSIONER CHAMBERS: Yeah, but I can tell you as a former regional office CMS person is we did enforce it. But that -- maybe CMS does that now, but we certainly did then.

My real question was, though, is I didn't hear anything mentioned, some of the background materials talked as one possibility for dual eligibles is to explore expansion of the PACE program. We certainly don't have to go into it here, but I think it's certainly something to explore. As we're in the process of bringing up a PACE program, I can tell you -- you know, in reading the background materials, it is a difficult, expensive program and limited applicability. But with some tweaks to the program, I think it potentially could be something as to really getting fully integrated care for dual eligibles. So I just wanted to make sure that was still on our radar screen, to look at that maybe a little farther than out than this stuff we focus on.

MS. NEMORE: Yeah. We've generally not heard much in the way of difficulties with PACE except for the lock-in to providers, which is true in most managed care systems. You're locked into a network of providers, but that seems to be the one thing that people might not like about it, but once they choose that system, it seems

to work very well.

CHAIR ROWLAND: Well, I think this is rich area for continued discussions and I want to thank both Trish and Chuck for joining us today, and Christie, for pulling the panel together. This is clearly a topic that we will be revisiting. I think, Judy, your point about looking at the eligibility as a part of before we get to coordination is really critical and that has to stay on our agenda, too. Thank you very much.

MS. NEMORE: Thank you.

CHAIR ROWLAND: Now we will take the opportunity to hear any comments from the public about the issues we've covered today or the agenda we have going forward. I would just ask that if you take the mic, you identify yourself and your group so that we know who's talking to us. Thank you.

PUBLIC COMMENT

MS. VOTAVA: Hi. I'm Pat Votava and I'm the director of government relations for the Children's Hospital at the Medical University of South Carolina. First of all, thank you for your work. It's a tremendous amount of work that you've done in a very short period of time and I know that you've got a very full plate.

After listening to the discussion today focusing on quality

and access and outcomes and cost containment and the political climate that we find ourselves in, both on a state level, and I agree, I think the states are going crazy and a lot of that really is because the don't have any money and they're getting all of these mandates and they don't know what they're going to do about it. And also, all the changes that we've got going on a federal level.

I would like to take a few minutes to offer up one more model that you may want to take a look at that's got a good amount of data collection done with it. This is a model for a special needs population for children that started in South Carolina.

I must say we're proud of it because we don't have a whole lot coming out of South Carolina that's necessarily a national model, but this is one that has had great success, and, in fact, was part of the best care and administrative practices work group from the Robert Wood Johnson Foundation in the early 2000s that was used as a model.

Just before health care reform came up on a congressional level, there was a bill that had bipartisan support both on the Senate side and the House side that was introduced at the end of the congressional session in 2008 to make this a national model.

It is a partially capitated plan, so that really goes to

providing cost containment for the states, which was really essentially with the high cost, high user population, and to go to what was discussed about access and utilization.

What it did was, it was a public/private partnership actually with the children's hospitals in the state and with Medicaid and with the Department of Social Services because it involved both children in foster care as well as biological children that are special needs.

All the services were delivered at one location with the provider bearing risk. The only services outside of the plan were actually inpatient hospital care, and outpatient surgery, and it included -- one of the great things was it included those services which Medicaid, in fact, does not pay for on a fee-for-service basis, but that are so needed.

The Duke Endowment provided money for a data collection model which was actually a fairly successful data collection model, but has been paid for, and that would be information available to you as well. And the National Association of Children's Hospitals did a case study on the program that was held up as an innovative Medicaid model, one of the first ones.

I know we talked at the break. Diane was saying that I know

there have been discussions on that. I think the things that are most impressive about this are that there was also a comparison group that the state Medicaid agency put together, and so these were kids in fee-for-service that had same or similar diagnoses as the children enrolled in the plan.

The outcome data showed that the outcomes for the children enrolled in the plan, 100 percent improvement in health care outcomes. The cost containment piece was that the plan actually saved the state Medicaid agency $10,000 per year per enrolled child, and that cost containment, particularly in the environment that we're looking at, is something huge to be able to offer up.

On the foster care side of it, the adoption rate, 60 percent of the children were adopted; whereas, children who were in the fee-for-service system or were special needs, less than 5 percent.

So that also provided -- I know we're not necessarily talking about social service agencies and providing cost savings for them, but certainly that's an additional benefit to the state, that you can show stability in foster care placement and that you can also show increase in adoptions, so you're getting those children off of those rolls.

That partially capitated piece, I think, does answer some

of the things that people have been struggling with, how do we keep some in and some out, and what works, you know, the struggles with that as we've looked at this morning in terms of models and where do things get stuck is for awhile politically. In the change in administrations, demonstration models were no longer encouraged.

Now we're in an environment once again where demonstration models can be done, but also giving states the flexibility to design them in an environment that might work for the states. So we certainly offer that up and I offer that to you in conjunction with the National Association of Children's Hospitals.

As a model, we can quickly get you that case study for you to look at that might save you some time from reinventing the wheel on that particular level. So once again, thank you.

CHAIR ROWLAND: And thank you and we look forward to receiving that material and we'll take it into consideration as we look at models and best practices.

Are there any other comments? With that, then we will adjourn this meeting and wish you all a safe and happy holiday season and we'll see you in the new year. Thank you very much.

[Whereupon, at 12:31 p.m., the meeting was adjourned.]

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