MACPAC

Medicaid and CHIP Payment and Access Commission

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

Thursday, February 16, 2012
1:06 p.m.

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

LU ZAWISTOWICH, ScD, Executive Director

AGENDA PAGE

Session 1: Chapter Review: Medicaid and persons with disabilities
Population characteristics for persons with disabilities
April Grady, Principal Analyst
Chris Park, Senior Analyst 3

Services and spending for persons with disabilities
April Grady, Principal Analyst
Molly McGin-Shapiro, Analyst 10

Quality measures for persons with disabilities
Jennifer Tracey, Senior Analyst 16

Staff Contact: Christie Peters, Principal Analyst

Session 2: Chapter Review: Program integrity in Medicaid
Caroline Haarmann, Senior Analyst 19

Session 3: Chapter Review

Access to Care for children enrolled in Medicaid and CHIP
Chris Peterson, Director of Eligibility, Enrollment and Benefits 25

State Medicaid financing and implications for payment
Jim Teisl, Senior Analyst 42

Session 4: Update on MACStats
April Grady, Principal Analyst
Chris Park, Senior Analyst 48

Public Comment 53

Meeting Discussion wrap-up 54

Adjourn 55

1 P R O C E E D I N G S [1:06 p.m.]

2 CHAIR ROWLAND: Okay, if we can please come to order. We want to continue our
3 discussion that we've begun over the last few meetings to come to closure on the report that we will deliver
4 to Congress in March, and so our first area that we are exploring in this report is on Medicaid and persons
5 with disabilities. And so I'm going to ask April and Jennifer to begin our discussion here with is.
6 Unfortunately, Christie Peters could not be with us today, but I know April and Jennifer will take us through
7 the main outline and main key points of the chapter, and then we want to talk about the recommendations.
8 So, April?

9 ### **POPULATION CHARACTERISTICS FOR PERSONS WITH DISABILITIES**

10 * MS. GRADY: Thank you, Diane.

11 As you just mentioned, we're going to talk today about the chapter overview and talk about some
12 updates that we made since our January meeting in response to your comments and others', and then we'll
13 go through the Commission's recommendations for you to discuss and vote on today.

14 In the chapter on persons with disabilities, the overview section of the report makes some key
15 points. A focus of this chapter is on Medicaid-only enrollees, and that's in part because they are both the
16 majority of enrollment and Medicaid spending on persons with disabilities.

17 At the last meeting, we talked about some of the key issues that are guiding the Commission's work
18 on this population, and these include benefits, access, quality, care management and coordination, and best
19 practices and program evaluation.

20 In the last meeting, we also talked about key points that are made in the chapter. These include the
21 fact that Medicaid enrollees with disabilities are a heterogeneous group. They have poorer health status
22 and greater presence of health conditions and functional limitations than other Medicaid enrollees. As a
23 result of their high health needs, the overall population of Medicaid enrollees with disabilities represents a

1 disproportionate share of Medicaid spending. Folks with disabilities are about 15 percent of Medicaid
2 enrollment, but more than 40 percent of Medicaid spending.
3 Again, a key point in this chapter is that within the overall population of enrollees with disabilities,
4 the Medicaid-only subgroup -- in other words, the subgroup of people whose primary coverage is the
5 Medicaid program, people who are not dually enrolled in Medicare -- that Medicaid-only subgroup accounts
6 for the majority of enrollment and spending.
7 The other issue we discussed is that more research is needed to determine the extent to which
8 quality measures adequately address the needs of persons with disabilities, and Jen will talk more about that
9 later today.
10 Now what we want to do is walk you through the sections of the chapter and provide you with
11 information on updates and additions that have been made since we last met.
12 In Chapter Section A, which deals with the characteristics of Medicaid enrollees with disabilities, one
13 of the things that we did was to clearly distinguish between the overall population of Medicaid enrollees
14 with disabilities versus subgroups. So, again, here what we wanted to do is clearly draw a line between the
15 Medicaid-only enrollees subgroup and persons who are dually eligible for both Medicare and Medicaid.
16 We also clarified the definition of "disability" used by Medicaid and provided more information on
17 eligibility pathways for persons with disabilities.
18 In response to your comments, we also included more information on behavioral health conditions
19 which are common among the most expensive enrollees.
20 Again, we keep coming back to this point, but it's one that the Commission has urged us to
21 emphasize in this chapter, and that is the fact that not all Medicaid enrollees with disabilities are dually
22 eligible for Medicare, and here you see that about 62 percent of Medicaid enrollees with disabilities are
23 Medicaid only, and those enrollees account for about 70 percent, almost 70 percent of Medicaid spending.

1 CHAIR ROWLAND: [off microphone] On people with --

2 MS. GRADY: On people with disabilities, correct, within the subgroup of people with disabilities

3 in Medicaid.

4 Moving on to Chapter Section B, which is about services and spending, one of the things we did

5 here was to clarify that, in addition to Medicaid benefits differing from other payers not only in the breadth

6 of coverage, so the types of services that are covered, Medicaid benefits also differ in their depth in terms of

7 the amount, duration, and scope of those benefits.

8 In terms of breadth, we talk about long-term services and supports, but also behavioral health where

9 services provided in the community and outside of the clinical settings typically covered by private insurance

10 are a feature of the Medicaid program.

11 In terms of depth, we gave EPSDT, which is early periodic screening, diagnosis, and treatment

12 services, as an example where children are not subject to the limits and caps on benefits that may be typical

13 in private insurance and other types of coverage.

14 In addition, we provided more context for the Medicaid spending figures that are in the chapter.

15 For example, we discussed the fact that managed care is a relatively small share of spending for persons with

16 disabilities right now, but there's growing interest among states in this delivery system as a method for

17 coordinating care and achieving budget predictability and potentially savings as well.

18 We also noted that mental illness is nearly universal among the highest costs, most frequently

19 hospitalized enrollees.

20 Additionally, in this section what we did was to be sure to emphasize that all of the spending

21 amounts in this chapter and in this report are limited to Medicaid, and they don't reflect the total costs for

22 persons who are dually eligible for Medicaid and Medicare. Again, that's an issue we'll be tackling in the

23 future.

1 Now I will turn it over to Jen to talk about quality.

2 MS. TRACEY: Thanks, April.

3 COMMISSIONER RILEY: Before we do, April, on the data -- I think this is much improved,
4 and I think we still could do better with our headline about the Medicaid only and be more affirmative
5 about that because it is an important finding. But throughout it, I think we still have yet to get fully an
6 appreciation for the complexity of this population, and partly that's a data issue, I think, because it's all
7 mushed under long-term services and supports. So I would like to know how much money we spend on
8 idea -- which translated is "idea" -- it doesn't have an "R" in it, does it? And then to look at PTOT
9 targeted case management, the subsections -- we define them in the narrative, but when you look at the
10 charts, it's all bunched under long-term services and supports. Actually, that will be more important when
11 we look at the duals. But it seems to me the more we can disaggregate that and understand the real
12 complexity of this population and their service uses, where the money goes, especially inter-title transfers,
13 into mental health agencies, into educational agencies, I think the more value added here.

14 As a minor point, on B-4, I think it's always sad when the circles have to look the same even though
15 one represents $97 billion and the other represents $47 billion. And I just want to make sure we drive
16 home the fact that $974 billion of expenditures is state only that states can do something about today
17 without Medicare and without all the complexity of dual eligibles. And I think either make the headings
18 bigger or the circles bigger.

19 MS. GRADY: Thank you.

20 COMMISSIONER RILEY: I worry about these important issues, how big the circles are.

21 CHAIR ROWLAND: And I think one of the points we've tried to make throughout this
22 discussion is that this is a population that doesn't require the kind of coordination with Medicare that the
23 dual-eligible population requires, so that the dollars are not state-only dollars; they include federal dollars.

1 But this is a place where the states have the ability through Medicaid to control the service patterns and use
2 for this population, and I think that's a point we want to make very strongly in this chapter. Let's look at
3 how to take care of Medicaid's disability population where you don't have to coordinate with Medicare and
4 see if those models may be applicable down the road to giving us some guidance on how to handle the
5 duals.

6 COMMISSIONER COHEN: Just because Trish laid the groundwork for this so nicely, I just
7 wanted to throw out an idea, maybe not for this report if it's too late but for down the road. I think it
8 would be -- because in our work to date it has been clear that there are so many data limitations in different
9 kinds of areas, I think it would be useful if as a practice we highlighted what the data limitations are in any
10 given area, a box or a point in every -- you know, sort of in every chapter so that we are, you know, sort of
11 reminding ourselves and otherwise, you know, kind of what are the pieces of information that we really
12 need and can't get, and at some point down the road we may be able to make some broader observations or
13 even recommendations around prioritizing them. So it would be great to just block them out.

14 COMMISSIONER EDELSTEIN: I wanted to point out in that figure that Trish took us to,
15 Figure B-4, the top figure, that while 100 percent of these people have mouths--

16 CHAIR ROWLAND: Really?

17 COMMISSIONER EDELSTEIN: Indeed. While 100 percent of them have mouths, the total
18 spending on dental care, because there is no adult mandate, is virtually zero. It's definitely less than 1
19 percent. And I think that adding a notation to that box showing that less than 1 percent goes to dental and
20 then amending the text to point out that the oversight of inclusion of dental services for adults accountable
21 for that low spending.

22 VICE CHAIR SUNDWALL: But, Burt, it's an optional service, and some states do provide it,
23 right?

1 COMMISSIONER EDELSTEIN: It's easy to provide the information on which states do, but
2 we're down to about five states that provide anything reasonably comprehensive.
3 COMMISSIONER MOORE: For adults.
4 COMMISSIONER EDELSTEIN: For adults.
5 VICE CHAIR SUNDWALL: We used to early in my tenure at Utah, and then we lost it.
6 CHAIR ROWLAND: Okay.
7 MS. TRACEY: Okay. So based on the feedback that we received from the Commission during
8 our January meeting, I wanted to highlight some of the areas in which we have made changes to the
9 Medicaid enrollees with disabilities quality section.
10 In the section introduction, we added additional details about the services used by Medicaid
11 enrollees with disabilities as compared to other Medicaid enrollees. We also highlight how their spending
12 differs, and this information does reflect the service use and spending data that's presented earlier in the
13 chapter.
14 We also emphasized that, given their comorbid conditions, complex treatment planning, and
15 frequent interactions with health care providers, it is necessary and critical to ensure that Medicaid enrollees
16 with disabilities receive quality care.
17 Finally, we also emphasized that the research and scientific evidence needed to inform the
18 development of quality measures to address disability-related issues is limited. For this reason, it is still
19 unknown as to whether additional quality measures are needed to assess quality of care for this population
20 or whether special considerations for these individuals are needed.
21 In the latest draft, we highlight certain quality improvement level efforts at the federal level which
22 focused on improving quality for persons with disabilities, for children and adults on Medicaid, and for
23 Medicaid enrollees with complex health conditions and health homes. One of the most significant pieces

1 that we have added to this section details findings from an Agency for Healthcare Research and Quality
2 expert meeting, also known as AHRQ. This meeting was held in 2010 to explore the development of
3 quality measures for persons with disabilities and to develop a research agenda for AHRQ-focused measures
4 for this population.

5 Participants concluded that there are widely accepted and used quality measures for common health
6 conditions which can be severely disabling, such as asthma, heart failure, and diabetes. However, most of
7 these measures do not address special considerations for persons with disabilities.

8 Participants also concluded that the body of research and scientific evidence to guide quality
9 measure development for persons with disabilities is limited. For this reason, relatively few quality
10 measures exist which specifically address disability-related issues.

11 We also include several of the key research questions that were raised by participants. For
12 example, as quality metrics are designed that apply to large numbers of patients with common conditions,
13 are there special considerations for persons with disabilities? How should any special concerns relating to
14 disability be factored into quality measurement? Recommended priorities for AHRQ's future research
15 related to this area are also included in our draft.

16 In regards to the HHS adult and children core quality measures, we included additional details on
17 the types of measures in each of these measure sets as well as the actual measures in the chapter annexes.
18 We have also added in the CMS seven quality measures for health homes. States must report on these
19 measures if they provide coordinated care through a health home for certain complex Medicaid populations,
20 such as persons with multiple chronic conditions.

21 We have also added a section that provides additional information on HEDIS and CAHPS,
22 including an overview of the types of HEDIS measures, and an overview of the CAHPS surveys, including
23 those for children with chronic conditions and persons with lower limb mobility impairments. The

1 annexes for this section now include the adult and pediatric core measure sets as well as the state-specific

2 quality measures for high-need, high-cost populations that we discussed in our previous meeting.

3 Now I will turn it back over to April who will talk about our first recommendation for this chapter.

4 ### **SERVICES AND SPENDING FOR PERSONS WITH DISABILITIES**

5 * MS. GRADY: Thank you.

6 Right now our first draft recommendation for consideration by the Commission is that, "The

7 Secretary and the states should accelerate the development of program innovations that support quality,

8 cost-effective care for persons with disabilities, particularly those with Medicaid-only coverage. Priority

9 should be given to innovations that promote coordination of physical, behavioral, and community support

10 services and the development of payment approaches that foster cost-effective service delivery. Best

11 practices regarding these programs should be actively disseminated."

12 I'll talk for a few minutes about our rationale and the potential budgetary impact of this

13 recommendation before I open it up to you for discussion.

14 A key rationale for this recommendation is that persons with disabilities are a high-need, high-cost

15 population. These individuals would benefit from innovations that improve the quality of care they

16 receive. In addition, states and the federal government would benefit from the delivery of more

17 cost-effective care to this population.

18 A second key point is that opportunities do exist for this population right now. An example of a

19 specific opportunity for innovation is the $1 billion that will be awarded this year under the Health Care

20 Innovation Challenge issued by the Center for Innovation at CMS.

21 The Commission has also discussed the Innovation Center at CMS more broadly as an opportunity

22 to fund projects that focus on persons with disabilities, especially those with Medicaid-only coverage.

23 In addition to presenting an opportunity to support new care coordination and payment approaches

1 for persons with disabilities, the Innovation Center can also play a role in disseminating information on
2 lessons learned.
3 A third key point we make in the rationale is that a great deal of recent policy attention has focused
4 on individuals who are dually eligible for Medicaid and Medicare, in part because they are a high-cost,
5 high-need population as well. However, what we highlight in this chapter is the fact that Medicaid-only
6 enrollees with disabilities are also a high-need, high-cost population that accounts for the majority of
7 Medicaid spending for enrollees with disabilities. A rationale for this recommendation is that these
8 individuals could benefit from increased policy attention as well.
9 As you know, we are required to assess the budgetary impacts of our recommendations, and what
10 we discuss in the chapter is that there is no immediate and direct impact on federal and state budgets from
11 this recommendation. But more effective and efficient programs for these individuals can both improve
12 access, quality, and outcomes, but also reduce state and federal Medicaid costs in the long run.
13 We also note that enrollees with disabilities and providers will both gain from the continued
14 development and support of program innovations that could provide better and more coordinated care for
15 these populations.
16 CHAIR ROWLAND: Discussion?
17 VICE CHAIR SUNDWALL: I have a question and comment. Thank you. Very good
18 overview of this chapter, and I think it will be quite enlightening to people that aren't aware of the
19 heterogeneity, if that's a word, of this population group. It's really a contribution.
20 My question. April, you just said there would be no apparent budget impact from our
21 recommendation, but if, in fact, there are newer and better quality measures, will this be a burden on states?
22 Do you see it will be more of a -- more quality measurement, more accountability, more data collection?
23 Or do you see this potentially replacing some quality measures that aren't so good? Or how do you think

1 this might play out?

2 CHAIR ROWLAND: That speaks a little bit to another recommendation, but you could comment

3 on it in this one.

4 MS. GRADY: I think here I believe the Commission was focusing on broader innovations that

5 involve perhaps service delivery and payment approaches. I think Diane mentioned we do focus

6 specifically on quality in the next recommendation, so if that's a particular issue, we could discuss that. It's

7 not directly addressed in this particular recommendation.

8 CHAIR ROWLAND: The one issue that could be a budgetary issue with this recommendation is

9 that if the innovation supports high-quality, cost-effective care, it still could be a more costly set of care for

10 some people who have had substantial unmet needs and may not have had the same level. So at least in

11 our rationale we should recognize that some of these systems could, in fact, end up meeting the quality

12 standard by also having to increase some of the scope of care.

13 COMMISSIONER RILEY: But, conversely, I would also say that this is a population that has

14 not been well attended to. It's so riddled with subgroups within it that I think it's also fair to say that it

15 could equally bring efficiencies and effectiveness to states if they deliver services differently, and we ought

16 to make it clear.

17 Also, part of the reason we haven't focused enough attention, I think, collectively on this population

18 is because we have been so enamored with the dual-eligible issue, and appropriately so. So whenever we

19 talk about it, I would not lead with duals are big but these are, too. I would flip it always and talk about

20 this is a finding about people with disabilities who are Medicaid only, who have not been adequately -- you

21 know, this is a group that has been pretty hidden from our focus. And so every time we have an

22 opportunity not to talk about duals, I would, because, clearly, we're going there and we'll do separate work

23 on that, and it's terribly important.

1 But I think this highlights the need that we need so much more information about what works for
2 this population, about what improves and maintains their functioning, and about what is efficient and
3 effective service delivery and payment, that I fear that we sometimes lose that in our constant framing it
4 around a dual-eligible issue.

5 CHAIR ROWLAND: The truth is within the Medicaid program this is a more costly population
6 than the dual share of this population.

7 MS. GRADY: Looking at the Medicaid side of expenditures only, yes.

8 COMMISSIONER RILEY: And it's the Medicaid program that -- I mean, that's my concern.
9 We're looking at the Medicaid program. We're thinking about the federal-state relationships of the
10 Medicaid program. The duals issue is a separate one that engages Medicare as well. But as a Medicaid
11 Payment and Access Commission, I just think we should -- can you tell I think we should really drive home
12 that this is a state population with implications for state budgets, for the people with disabilities that are
13 served, and to shine a light on what works well, what we can do better, what can be more effective and
14 efficient. I think it's an enormously important area that we've highlighted, and it loses a little of its patina
15 in the discussion with the duals.

16 COMMISSIONER MOORE: I totally agree, and I think based on what we have said in the
17 chapter and in the recommendations that we're going to continue our analytic work on this area of Medicaid
18 beneficiaries with disabilities who are not dual eligibles, because I think we have an awful lot to learn.
19 There are so many subgroups within that group, and it may be that there are different ways of delivering
20 services to different parts of that subgroup that hopefully we can address in coming years as we continue
21 this work.

22 COMMISSIONER GABOW: I would like to have someone clarify for me Figure B-4 because I
23 think I may be missing something important. I was a little surprised that the Medicaid-only group had only

1 25 percent of their costs be long-term services where the Medicare duals, the Medicaid/Medicare duals, it
2 was 63 percent. And I wasn't sure what conclusion to draw to this because in the Medicaid bin -- in the
3 dual-eligible bin, those services are in the Medicaid spending, and certainly for the Medicaid only, they're in
4 that bin. So is the conclusion that these patients are less sick, these patients are younger and, therefore,
5 don't need to be institutionalized, they have totally different diagnoses, like they don't have dementia which
6 might lead to institutionalization, or these services aren't covered for the Medicaid only? But that's such a
7 dramatic difference, 63 to 25 percent of big numbers. So I couldn't figure out when I read the chapter or
8 -- and there's no figure legends, which you know I always think should be after every figure. I didn't know
9 how to interpret that pretty dramatic difference, which wasn't really had a light shined on it.
10 CHAIR ROWLAND: Do you want to take a stab, April?
11 MS. GRADY: Sure. I think the issue you're identifying, first of all, is that this is Medicaid
12 expenditures only, and when we look at the dual-eligible population, to get a complete picture of their acute
13 and long-term care spending, we'd want to have both Medicaid and Medicare expenditures. So what you're
14 seeing here is a large --
15 COMMISSIONER GABOW: April, that would only make this difference bigger, so it doesn't -- if
16 we have 63 percent of the Medicaid spending versus 25, and we aren't even including the Medicare portion
17 --
18 CHAIR ROWLAND: But, Patty, it's because in the Medicaid-only people, Medicaid is paying for
19 all of their acute care and all of their long-term care, so that when you take 100 percent of what's being
20 spent, you've got all the medical assistance in there. And when you look at the dual population, you're only
21 looking at the share Medicaid chips in for their acute-care services. So when you do it on a percentage
22 basis, it comes out to magnify the role Medicaid plays in long-term care.
23 So it's an apples-to-oranges comparison. These two -- and maybe that's something we really need

1 to clarify here. These two pies are not measuring the same thing. Although there is also a truth to the
2 fact that people with disabilities who are under 65, both dual disabled individuals as well as non-dual
3 disabled individuals, tend to use more community-based services than institutional care. But I think the
4 confusion that's being raised here means that these graphics can have some additional text to explain them
5 and around it and that the dollar distribution is also one that's important, so the percentages hide some of
6 what's there, and maybe under each percent you could put the dollar distribution, because as you see,
7 Medicaid spends $47 billion on enrollees with disabilities who are dually eligible compared to $97 billion for
8 the Medicaid-only population, and most of that difference is in expenditures for acute-care services for the
9 Medicaid-only's.
10 COMMISSIONER EDELSTEIN: It may be likely that the single paragraph that's going to get the
11 most attention is the recommendation itself, and the point that we've made repeatedly about the majority of
12 people in Medicaid with disabilities are Medicaid only and not duals might be driven home by putting as
13 asterisk on particularly those with Medicaid-only coverage and indicating that 62 percent of the Medicaid
14 population with disabilities. I don't think we should mess with the text, nor bury it in the --
15 CHAIR ROWLAND: Rationale.
16 COMMISSIONER EDELSTEIN: In the rationale, but to highlight it somehow, perhaps with a
17 subscript.
18 CHAIR ROWLAND: Okay.
19 COMMISSIONER HENNING: And I'm kind of missing -- we were talking about having it have
20 a title, "Persons with Disabilities," and that was one of the reasons why I like the way it read before, but I'd
21 like to have a title with it. I'm missing the title.
22 EXECUTIVE DIRECTOR ZAWISTOWICH: We can include that title in the chapter. It just
23 fell off when we were revising the draft.

1 CHAIR ROWLAND: Other comments?

2 [No response.]

3 CHAIR ROWLAND: All right. All those in favor of going forward with this recommendation
4 and refinements later to the rationale for the recommendation, please indicate so by a show of hands. And
5 anyone who is opposed to the recommendation? And we have two Commission members who are absent
6 from the meeting. Okay.

7 VICE CHAIR SUNDWALL: We have a sheet here.

8 CHAIR ROWLAND: That's just for your information. The staff is recording the vote.

9 VICE CHAIR SUNDWALL: You don't need to record these? Okay.

10 CHAIR ROWLAND: Okay. Jennifer?

11 ### **QUALITY MEASURES FOR PERSONS WITH DISABILITIES**

12 * MS. TRACEY: Okay, and now we'll talk about our second recommendation for this chapter. It
13 is: "The Secretary, in partnership with the states, should update and improve quality assessment for
14 Medicaid enrollees with disabilities. Quality measures should be specific, robust, and relevant for this
15 population. Priority should be given to quality measures that assess the impact of current programs and
16 new service delivery innovations on Medicaid enrollees with disabilities."

17 The Commission's rationale for developing this recommendation includes several key points.

18 First, given that Medicaid enrollees with disabilities have more complex conditions and use many
19 more medical and other health-related services than average Medicaid enrollees, they may be more
20 vulnerable to poor-quality care.

21 Second, it is not clear whether or not standard measures are adequate for addressing the quality of
22 care provided to Medicaid enrollees with disabilities or if these measures should somehow be adjusted to
23 consider special health considerations, for example, adjusting dental measures to target enrollees with

1 disabilities.

2 Finally, there are widely accepted and used quality measures for common health conditions which

3 can be profoundly disabling. However, it is not clear if these measures adequately address special

4 considerations for persons with disabilities.

5 And at this point we look forward to your feedback on the recommendation and the rationale.

6 CHAIR ROWLAND: Okay. Discussion? Does the text in the chapter support this series of

7 recommendations? Are you comfortable with the language? Are there points you want to add to the

8 rationale?

9 VICE CHAIR SUNDWALL: Just one comment. We learned in our discussions this morning

10 that there is work going on now to address this, and I think it's reflected in the text of our chapter. Could

11 you just say a word about AHRQ's initiative on assessing the quality measures?

12 MS. TRACEY: Sure. Absolutely. It's definitely on their agenda. They held that expert

13 meeting in 2010 to help set the future agenda for the quality measure development for persons with

14 disabilities, and so that's something that they're moving forward with. They just recently at the beginning

15 of this year released a draft report that just closed for public comments I think last week that focused on

16 what are the outcomes that we need to be looking at when setting quality measures for persons with

17 disabilities, and they felt like that was kind of the first step in trying to develop these quality measures.

18 COMMISSIONER COHEN: I just want to emphasize the connection between the first and the

19 second recommendations, which is probably obvious. But, you know, I think that there are -- you know,

20 most people with disabilities in Medicaid as the chapter describes are not in managed care and

21 fee-for-service programs. There's a lot of interest in trying to create more coordinated arrangements for

22 them, but there is a great deal of fear for this very vulnerable population that we don't have -- whatever sort

23 of lack of accountability there may be today in terms of assessing the quality of care that they get that had

1 changed -- that really changes incentives and things like that is very scary. And so I think it is just so
2 critical to have, you know, good quality measures as a foundational piece to help make sure that as we are
3 thinking about potential innovations and changes and more coordination for this population, that there's a
4 real way to measure it and assess whether changes are working and change -- you know, to sort of course
5 correct if there are problems and things like that. And without this measurement system, we just -- you
6 know, we are driving blind. So it's a very -- I'm just making a very obvious point, but I want to just really
7 connect recommendation 1 and recommendation 2. We really need the quality measurement as, you know,
8 quickly as possible in order to drive smart change.
9 CHAIR ROWLAND: And also to provide for accountability, which should be part of the
10 rationale, as you pointed out.
11 Other comments?
12 [No response.]
13 CHAIR ROWLAND: Everyone's comfortable with the recommendation, with the rationale?
14 And if so, let us vote on this recommendation as the second recommendation in our chapter on disabilities.
15 All those in favor, signify by raising your hand? All those opposed? And noting our two absent
16 Commission members, Sara and Donna.
17 Okay. Well, we clearly are moving forward to have this as our lead chapter in the report going
18 forward to Congress in March. Any other comments that any of the Commission members have on the
19 draft chapters should be -- Monday is a holiday, so let's say Tuesday morning would be the last opportunity
20 to really send in any edits, any additions that you'd like to make beyond the ones that have already been
21 transmitted to Lu and to the staff. And I'd like to thank April and Jennifer for guiding us through this part
22 of the discussion.
23 We'll now turn to the other chapter in which we have recommendations related to program integrity

1 in Medicaid, and I'd like Caroline to come to the table to do a comparable walk-through of the chapter
2 itself, and then we'll discuss the recommendations and the rationale for those recommendations one at a
3 time for that chapter.
4 #### **PROGRAM INTEGRITY IN MEDICAID**
5 * MS. HAARMANN: Thank you, Diane.
6 Today's session will provide an overview of the changes to the draft program integrity chapter for
7 the March report, and we look forward to getting your feedback on the proposed chapter material.
8 Certain changes to the chapter are organizational to make sure readers are aware of what's addressed
9 in the chapter and the annexes, and the discussion around coordination has been reframed as cooperation to
10 try to better address the range of activities that involve various federal and state agencies.
11 With regard to content, the chapter now includes a table and discussion of the federal matching rate
12 for program integrity-related activities, and there's also additional discussion about the Medicaid Integrity
13 Institute, the need for streamlining, simplification, and feedback loops, and the possibility of CMS providing
14 additional guidance to states on analytic tools that states could choose to use when making decisions about
15 which tools to purchase.
16 The Commission is also considering two recommendations around program integrity. The first
17 potential recommendation under consideration is: "The Secretary should ensure that current program
18 integrity efforts make efficient use of federal resources and do not place an undue burden on the states or
19 providers. In collaboration with the states, the Secretary should create feedback loops to simplify and
20 streamline regulatory requirements, determine which current federal program integrity activities are most
21 effective, and take steps to eliminate programs that are redundant, outdated, or not cost-effective."
22 This first potential recommendation is aimed at making efficient use of resources. Federal and
23 State government agencies and providers are required by law to participate in various program integrity

1 activities, and there may be overlap and duplication of efforts at times because newer initiatives sometimes
2 repeated efforts already underway in existing programs. This recommendation could help address this
3 problem through administrative simplification, identification of successful efforts that could be further
4 expanded, and the elimination of redundant and outdated program integrity initiatives or those that are not
5 cost-effective.
6 CHAIR ROWLAND: Can you explain for the group what you mean by "feedback loops"?
7 MS. HAARMANN: Sure. That just has to do with when a problem or improvement is identified
8 -- or an area where there is improvement that could be made, that there are ways that providers or whoever
9 identifies the problem could address that through regulations or regulatory changes.
10 CHAIR ROWLAND: So that when a pattern is picked up, that it doesn't keep repeating itself.
11 MS. HAARMANN: Right.
12 CHAIR ROWLAND: That there would be a way to -- because I think it's important to define that
13 in our rationale so that it's clear what the intent of this particular recommendation is.
14 Other comments?
15 COMMISSIONER MOORE: The chapter reads really well. You've done a really nice job of
16 putting it together. And I think it's actually interesting, because if you look through it, the tables, the
17 charts, the appendices, the lists of who does what kind of in and of themselves give you a flavor for how
18 much is going on and make you want to ask the question: Is all this coordinated or, you know, should
19 there be a second look at it?
20 This is kind of a straightforward language, and it does not give you the same feeling as all those lists,
21 and so I'm perfectly comfortable with this, but I think it's hard not to think that maybe there might be some
22 efficiencies that could be found by a complete review of this since it's an area where lots and lots of
23 statutory language has been added over the years and maybe just a pile-on kind of effect possibly.

1 So I think I would have great hopes that some efficiencies might come out of this sort of review, but
2 nice job on putting it all together.
3 COMMISSIONER GABOW: I also think this is an important and well-described chapter. The
4 one thing that maybe I'm just in confusion about this afternoon -- I shouldn't have had that extra cookie or
5 something. But Table 4-2 I think is really important, and I think it visually shows an issue, but I had
6 problems understanding how the list of things going down the side and the list of things across the top
7 actually related. And maybe I'm just confused, because they seem like in some instances they're both
8 programs, and so rather than activity down the vertical, they also are programs. And so that creates
9 confusion.
10 So, for example, the first item going vertically is the fraud, abuse, and control program, which is an
11 entity, or heat, which is an entity, which is the second. If, in fact, it described more what the activity was,
12 then how many of these entities are doing the activity, I think it would have more clarity. But maybe I'm
13 just confused.
14 CHAIR ROWLAND: Well, there's a lot of activities here, and I think that's the point of what
15 we're trying to pull together, is which of these activities do what, who shares in them, who uses them, and
16 which ones are effective.
17 COMMISSIONER GABOW: Well, I know that's what the visual is supposed to do, and I think
18 that's important to show. But I think we have mixtures of apples and oranges in both the horizontal group
19 and the vertical. That's all I was trying to say.
20 CHAIR ROWLAND: Caroline, did you get that?
21 MS. HAARMANN: Yes.
22 VICE CHAIR SUNDWALL: Could I just make a comment? The timing of this is important,
23 and I'm sure that most people on the Commission appreciate that program integrity is just kind of -- there's

1 been such a strong interest in it because, in part, legislators are seeking any way to get savings, and I know
2 they go to these NCLS meetings and nationally and they're told, oh, you can get money if you'll just go after
3 inappropriate payments.
4 Having been responsible for a Medicaid program, I can tell you how frustrating it is when this
5 enthusiasm for the fraud and abuse and program integrity seems to be a proxy for how can we cut your
6 budget or how can we get savings out of this program. And I understand their intent makes sense, and we
7 certainly want every dollar spent on Medicaid to be appropriate. But the tools I think will be helpful, if we
8 can get some guidance there, because if you are responsible for these large expensive programs, you're
9 bombarded with vendors wanting to sell you this or that, or the prepayment or the postpayment review, and
10 it really is kind of maddening if you're in a position to try and make these decisions, and then wondering if
11 it's going to pay off.
12 So it's my impression return on the dollar is not good, and I think this chapter is going to help
13 stimulate the debate or maybe some policy attention to this. It's timely and important, so I think that it
14 will serve a useful purpose to state Medicaid directors and hopefully policymakers, too.
15 CHAIR ROWLAND: And we also wanted to be sure in the rationale, remember, that we noted
16 that while it's important to have program integrity efforts, it's also important to invest in up-front program
17 management, and that we wanted to have reflected throughout the chapter.
18 VICE CHAIR SUNDWALL: Good point.
19 CHAIR ROWLAND: An ounce of prevention is worth a pound of cure, we can call that one.
20 Other comments?
21 [No response.]
22 CHAIR ROWLAND: Okay. So on recommendation 3 on program integrity that's on the board,
23 could I have a show of hands for those in support of the recommendation? Anyone opposed to the

1 recommendation, please show your hand. And we should note the two absent members of the
2 Commission.
3 Onward, Caroline.
4 MS. HAARMANN: Okay. The second potential recommendation under consideration is: "To
5 enhance the states' abilities to detect and deter fraud and abuse, the Secretary should: develop methods for
6 better quantifying the effectiveness of program integrity activities; assess analytic tools for detecting and
7 deterring fraud and abuse, and to promote the use of those tools that are most effective; improve
8 dissemination of best practices in program integrity; and enhance program integrity training programs to
9 provide additional distance learning opportunities and additional courses that address program integrity in
10 managed care."
11 This second potential recommendation is aimed at providing tools to states in their program
12 integrity work. In particular, providing states with guidance on ways to quantify activities that prevent
13 fraud and abuse could help to show the value of these activities which reflects the Commission's belief that
14 improving program management and allocating sufficient resources to do so is a key component in ensuring
15 the integrity of the Medicaid program.
16 The Commission has also heard from states that they frequently receive proposals from vendors
17 promising effective technological solutions to help in their program integrity efforts and that currently each
18 state has to independently try to assess and verify these claims.
19 And, finally, feedback from the states has indicated that the training received at the Medicaid
20 Integrity Institute has helped them better address program integrity issues. Additional distance learning
21 opportunities could allow a broader group of state staff to participate, especially for those whose state does
22 not permit travel even when it's at no cost to the state; and with so many Medicaid enrollees being enrolled
23 in managed care and states continuing to move additional populations into managed care, it's important that

1 states be adequately prepared to address program integrity issues in this area.

2 CHAIR ROWLAND: We did also want to stress that these opportunities could also be made

3 available to other individuals other than just the state program integrity units, providers, and other groups so

4 that the training could be broader based than just for program integrity staff, through webinars or whatever

5 other -- so that should, I think, be clear in the rationale.

6 Other comments?

7 COMMISSIONER COHEN: Again, just to highlight maybe some of what is obvious a little bit,

8 but I think that one thing that this recommendation is trying to do is to in this narrow area reflect some way

9 of slightly trying to improve the state-CMS relationship in such a way that CMS' oversight activities can be

10 sort of optimally helpful to the states and helping them to find the most cost-effective tool or, you know,

11 prevent the re-creation of the wheel, I think that's a really important justification for a significant portion of

12 this recommendation. Again, it's just sort of another theme, I think, in our work to keep in mind going

13 forward.

14 COMMISSIONER WALDREN: Just a small tactical piece. In the impact for the second

15 recommendation, you talk about the fiscal impact, you may want to reference back the first

16 recommendation. We're asking them to look at the federal programs so they could not have to repeat

17 those same things, so the impact would be, you know, shared across those two recommendations.

18 CHAIR ROWLAND: Other comments, suggestions, additions to the chapter or to the rationale?

19 [No response.]

20 CHAIR ROWLAND: All right. All those in favor of this recommendation on program integrity,

21 signify by raising your hand. All those opposed? And please note our two absent Commission members.

22 Again, if one wants to have any other comments on this chapter with regard to the charts, with

23 regard to the text other than the recommendations, with regard to the rationale, please let the staff know by

1 Tuesday morning at the latest.

2 Thank you, Caroline.

3 Okay. I think given the time we'll move right into the next discussion of access to care for children

4 and our chapter on that. So if Chris Peterson would please come to the table?

5 ### **ACCESS TO CARE FOR CHILDREN ENROLLED IN MEDICAID AND CHIP**

6 * MR. PETERSON: Good afternoon. I want to go through our chapter. The purpose is to

7 describe the changes we've made since the last version that you saw and to obtain any additional feedback

8 and guidance on the chapter and to remind you that, in addition to the chapter itself, online will be a

9 contractor report and a technical appendix that goes with that that will provide a lot of the technical detail

10 that folks might be interested in and more detailed findings.

11 The chapter outline has changed only slightly and that is to add the second section on the

12 methodology overview, which I will describe in a bit more detail here in a second, but still retaining the

13 other pieces, which were providing the results using the access framework and then the looking forward

14 section at the end.

15 So let me just go through my list of things that have changed since the last version in response to

16 your comments.

17 First of all, we wanted to make very explicit that we are using the regression adjusted estimates, so in

18 most cases, the controls that we used to adjust for enrollee characteristics did not alter, or did not tell a

19 substantially different story.

20 So the first two bullets that are on the first page are essentially the same, that the data show that for

21 almost every measure of access to care, children enrolled in Medicaid and CHIP have access that is

22 substantially better than similarly situated uninsured children as reported by a parent or another

23 knowledgeable adult in the household.

And two is that while comparisons between children with Medicaid or CHIP and similarly situated children with ESI yield a more complex picture, their health care access and use are comparable in terms of having a usual source of care and a couple other examples.

The new point is the third one, again, trying to emphasize that we're using the regression adjusted estimates. This chapter focuses mainly on how access to care and service use are affected by the source of health insurance of similarly situated children, controlling for underlying health, socio-economic, and other factors that cause children with Medicaid or CHIP to differ from other children. While these adjustments had a substantial impact on only a few measures, the more detailed findings suggest that factors beyond health insurance can also have a large impact on access to care, regardless of health insurance status.

So the second page is the methodology overview, which pulls up some of the information that was in the annex and that is in the more technical information. The two points of the methodology overview are to summarize the regression controls, why they were used, and then the second point is to emphasize that these findings are from survey data of individuals, of families, so that in this case, mostly as reported by parents. So this is to complement -- these kinds of data are to complement analyses that may come from other sources of data like administrative data or provider surveys. And we note in this overview that the limitations of these survey data are that they rely on parent recall, which may not be accurate, that parents may feel pressured to provide certain socially acceptable answers, for example, by indicating that their children received well-child visits even if they did not. So that's the purpose of the methodology overview in response to your comments.

We also note in the findings additional examples where the controls mattered besides the use of specialty care, and we put the term "similarly situated" in every figure so that it would be very clear that we were using the regression controlled estimates.

So those were some of the big changes. Some of the minor changes were that -- you remember

1 Figure 2 looked different from what was in the text, so we altered that figure so that the figure and the text
2 both were talking about the percentage that were Hispanic and below poverty.
3 On delayed care, there were two figures on delayed care that were confusing because one of the
4 figures showed this is the percentage overall who delayed care for any reason, and then the other showed
5 specific reasons and it was kind of confusing about how they all rolled up. So rather than using figures, we
6 have inserted a table to replace that so that it's clear that we're looking at delayed care for any reason, and
7 then the reasons underneath that.
8 And finally, we --
9 CHAIR ROWLAND: That's Table 2.1, right?
10 MR. PETERSON: Yes, that's right.
11 CHAIR ROWLAND: Page nine.
12 MR. PETERSON: And then also in response to Commissioner comments, we made the point
13 when talking about usual source of care and who that usual source of care is that regardless of your health
14 insurance status, if a child has a usual source of care, that usual source of care is usually a doctor's office.
15 The secondary point, then, is that Medicaid and CHIP children are more likely to have a clinic as a
16 usual source of care compared to other kids. I will note on that point, the reason we used doctor's office
17 in that case and not a provider's office is because that is what the survey says. So in response to your
18 feedback, anytime we could say "provider" rather than "doctor," we did so. But in cases where it was not
19 appropriate to change that, we did not.
20 So that summarizes the changes that were made since the last version that you saw.
21 CHAIR ROWLAND: Okay. Any other -- Steve.
22 COMMISSIONER WALDREN: I think I know the answer. When you said "clinic," you mean
23 the community health clinic?

1 MR. PETERSON: Yes.

2 CHAIR ROWLAND: Burt.

3 COMMISSIONER EDELSTEIN: I think this chapter is strong, but there are a number of issues,
4 four in particular, that I would like the Commissioners to think through with me because they caught my
5 attention and I think they're worthy of some further discussion.

6 I want to start with the most straightforward. The most straightforward is that the figures clearly
7 state that these are all similarly situated children, and I think it's equally important to state in each one of
8 these findings that these are parent reports, or these are caregiver reports or family reports, because they are
9 from the National Health Interview Survey, they are responses that are likely influenced by social
10 desirability, and I think it's as important to state that these are parental reports or family reports as it is to
11 state that they are adjusted for similarly situated children. So I wanted to see if there was consensus
12 amongst the Commissioners on that issue. So I started with an easy one.

13 [Laughter.]

14 COMMISSIONER EDELSTEIN: The next one is about the use of the schema that we
15 developed initially for our first report where we divide access into availability and utilization, and this one is
16 particularly important because this child chapter, as we've discussed, is sort of a prototype for now looking
17 at adults going forward.

18 In the schema, we say that access is a combination of the availability of services, that is, are there
19 providers, are the doors open, and utilization of services, that is, do people walk through the doors. And I
20 think that using NHIS and MEPS, we can only say that the findings somehow reflect a combination of
21 both. And so the repetition of the schema is very useful for reinforcing what we said before. But trying
22 to dichotomize the chapter into a heading called "Availability" and a separate heading called "Utilization"
23 doesn't work because the findings actually result from a combination of availability and utilization. They

1 can't be so cleanly divided. The particular reports that fall under "Availability" truly are availability. The

2 ones that fall under "Utilization," the way the chapter is now structured, are not necessarily utilization at all.

3 They are a combination of availability and utilization.

4 So I would suggest that we say up front, this is what we know about access. It's made up of two

5 halves, is the care available and do people utilize it. From these data, we can see certain things about

6 availability, but in terms of use, the use of services is a combination of both and not try to claim that the

7 second half of the chapter is really about utilization.

8 Did that make sense? I have a lot of curious looks around the table.

9 So I think we've pushed too hard in this chapter trying to claim that the latter findings reflect

10 utilization rather than reflect a combination of availability and utilization. Is that clearer?

11 So I'm still very supportive of the schema, but I don't think that the portrayal of the data, dividing it

12 between availability and utilization, holds water and needs to be softened.

13 CHAIR ROWLAND: Norma.

14 COMMISSIONER ROGERS: I just have a couple of comments. I hear what you're saying,

15 Burt, and I agree with you. I guess when I read this chapter, and I think I may have stated this before, but

16 I'm going to say it again, and that is that I find it interesting that -- for instance, on page nine underneath

17 Table 2-1, everything seems to be so positively given that children who had a condition that needed care

18 right away, the child got care as soon as needed. There was no problem with appointments. There was

19 no problem with this, this, and this.

20 And I find that very interesting considering the fact that in the literature that I read, in particular

21 about Latino population, which is in Texas we're primarily Latinos, predominately Latinos, there are many

22 barriers to accessing health care -- transportation, language. I mean, it's multiple. We're the highest -- we

23 have the highest rate of uninsured children in the United States and I just -- this doesn't make sense to me.

1 CHAIR ROWLAND: But --

2 COMMISSIONER ROGERS: If I might, using the service that you all did use, I understand

3 where Burt is coming from because I think that when you interview or do a survey with someone who is

4 underserved and uneducated, they are more apt to say everything is great for fear that if they don't say that,

5 it may be taken away from them. So I guess I'm just kind of wondering how objective are the surveys that

6 are being utilized to make these type of conclusions.

7 CHAIR ROWLAND: Except that you're pointing to Table 2-1, which is delayed medical --

8 COMMISSIONER ROGERS: I was really talking about the information underneath it.

9 CHAIR ROWLAND: Yes, which is delayed medical care. So 17 percent of Medicaid and CHIP

10 enrollees, 16 percent of those with employer-sponsored coverage, and nearly 30 percent of the uninsured

11 reported that they delayed medical care for some reason. The reasons are a little more distributed among

12 the Medicaid population and overwhelmingly due to cost because of the uninsured population. But I think

13 maybe the way these percentages are showing up, it's not that only eight percent of all Medicaid beneficiaries

14 had trouble waiting too long to see a doctor. It's the distribution within that 17 percent.

15 COMMISSIONER ROGERS: Okay.

16 CHAIR ROWLAND: And so I think we're not -- we may have a problem in how this table is

17 depicted that we need to explain more.

18 COMMISSIONER ROGERS: Oh, okay. Yes.

19 CHAIR ROWLAND: But I think 17 percent saying they delayed medical care reflects some

20 problems in the system among some, almost 20 percent of the population on Medicaid.

21 COMMISSIONER RILEY: I was just going to go back to Burt's point, if we can --

22 CHAIR ROWLAND: Yes.

23 COMMISSIONER RILEY: -- because I'm befuddled. Are you saying, Burt, that we should call

1 it all access and not -- or to fundamentally rewrite it?

2 COMMISSIONER EDELSTEIN: No, no fundamental rewriting.

3 COMMISSIONER RILEY: Okay. All right.

4 COMMISSIONER EDELSTEIN: I think just call it all access --

5 COMMISSIONER RILEY: Yes.

6 COMMISSIONER EDELSTEIN: -- and get rid of that heading called "Utilization" because it

7 isn't really utilization. It's a combination of utilization and availability.

8 CHAIR ROWLAND: And other factors. I mean, all the barriers that Norma has just mentioned

9 influence utilization as well as availability of providers.

10 Sharon and then David.

11 COMMISSIONER CARTE: That's what I was going to ask Burt. We're just saying that this is

12 one set of data, but we really want to build on this to look at real utilization data, particularly with respect to

13 specialty services, I think, because this is not a complete picture, is that right?

14 COMMISSIONER EDELSTEIN: Indeed, and that brings me to my third point, which is that I

15 think the title of this chapter could be enhanced by calling it access to care -- access to primary medical care,

16 because that's really what it's about.

17 VICE CHAIR SUNDWALL: Mm-hmm.

18 COMMISSIONER EDELSTEIN: There's the one section on specialty care and it suggests that

19 there are problems with specialty care. That's lines 261 to 285. And there can be in the introduction,

20 early on in the chapter, a reference to GAO and other studies that show that there are significant problems

21 with specialty care and dental care, but that this chapter focuses specifically on primary and preventive

22 medical care, which is very strong.

23 I don't want to lose the message that Medicaid is very effective in getting kids primary medical care.

1 But I do want to keep from leaving the impression that everything is completely rosy and that there aren't
2 other issues that need to be attended to.
3 CHAIR ROWLAND: Well, perhaps the other issue that goes with that is that this is not an
4 in-depth examination of access to care for children with Medicaid and CHIP. It's a comparison of how
5 children with Medicaid and CHIP compare to those who are privately insured and those who are uninsured,
6 but from a similar income, socio-economic background.
7 Did you have a point, Chris?
8 COMMISSIONER EDELSTEIN: But on primary medical care.
9 CHAIR ROWLAND: Right.
10 MR. PETERSON: I would urge caution on that front for just a couple reasons. One, I think
11 you've already mentioned that the specialty care is mentioned there, but in addition, a lot of the measures are
12 not specific to primary care. So they are, for example, whether medical care was delayed, and it's not was
13 medical care delayed for primary care. It's whether medical care was delayed at all.
14 What was your ease of obtaining necessary tests, and that does not distinguish between primary or
15 specialty care. Does the doctor listen carefully? Does the doctor spend enough time? Neither of those
16 are bifurcated primary care versus specialty care. And you're right, it probably is the case that the bulk of
17 those were primary care, but that's not how they were worded. So that would be my concern.
18 COMMISSIONER EDELSTEIN: Then I'd be happy to drop the primary preventive and just say
19 medical care.
20 CHAIR ROWLAND: He just means that dental care is not included here.
21 COMMISSIONER EDELSTEIN: Well, that's not only important to be reinforced, but then -- so
22 that's on scope. And then on the adjustment versus the unadjusted, there's an increasing body of literature
23 that says that social factors are, in fact, determinants of health, not just correlates of health. The whole

1 field of social determinants of health. As such, they are now regarded as parallel to, if not equivalent to,
2 biological determinants of health. And when we do these adjustments, and I fully understand the
3 regressions and fully understand why the adjustments are done -- we're trying to tease out the piece that is
4 coverage -- I think that the inclusion in a number of places of the unadjusted rates really, really helped,
5 because when you put in the unadjusted rates, as well, you can see a little bit more what the effect of social
6 determinants are.
7 So Chris has pointed out that for some of these measures, there's very little difference between the
8 unadjusted and the adjusted, and I think it's worth pointing out where that's the case and equally worth
9 pointing out where there is a significant difference.
10 So my last suggestion would be to take the nuggets that are pretty much in the last paragraph of each
11 section that say, this may indicate, or this may indicate -- particularly about the use of emergency rooms --
12 this may indicate that there's still a significant problem with regard to access, at least during certain hours of
13 the day.
14 And I think the chapter can be strengthened with a final paragraph that pulls out those observations
15 from each of the subsets and puts them together to say, on the one hand, things look really rosy because
16 kids are getting care, that parents are reporting that kids are getting care and in the similarly situated kids,
17 Medicaid is far better than having no insurance. But on the other hand, there are some warning signals
18 here in these data that need further investigation by the Commission.
19 CHAIR ROWLAND: And I think that would also need to have the caveat that we don't know
20 that the unadjusted rate for privately insured is a gold standard, either. I mean, the problem is that --
21 COMMISSIONER EDELSTEIN: Fair enough.
22 CHAIR ROWLAND: -- you have to figure out what you are comparing to and what the standard
23 is.

1 Trish.

2 COMMISSIONER RILEY: But, I think, to follow up, we could say something. Figure 2.7 on
3 specialty care and 2.9 on emergency, it is stunning when you look at it to see how close Medicaid and ESI
4 are, and that's because it's similarly situated kids. So these really pretty profoundly show us the effect of
5 poverty, as Chris points out, and it may be that we need to strengthen that, and these may be the two charts
6 where it would be interesting to look at the unadjusted data next to it.

7 CHAIR ROWLAND: And the unadjusted data is available in the background paper.

8 MR. PETERSON: Yes, and I think, actually, on that page --

9 CHAIR ROWLAND: And we talked about whether to put an appendix in or not.

10 MR. PETERSON: On that page, page 11, that's where the text actually walks through the
11 unadjusted numbers.

12 COMMISSIONER EDELSTEIN: That's very helpful. I think doing that in other places, even
13 where it shows no difference, that's telling, as well.

14 CHAIR ROWLAND: And we're going to have -- the longer background paper will be available on
15 the website.

16 David, and then Denise.

17 VICE CHAIR SUNDWALL: Burt said it better than I was going to, but it's exactly what I did.
18 My notes that I wrote on this on the plane back here are, this sounds just great. It sounds so fine. It's
19 terrific. And then I thought, well, I don't want to have the MACPAC look as though everything is rosy, is
20 the word you use. Then I look at the title and, in fact, we did what we said we were going to do. We
21 looked at the CHIP and Medicaid population compared with private insurance and that is good news and
22 something to celebrate. I think we've come a long way. Notwithstanding a Senator I know quite well
23 disclaiming his contribution to CHIP, I think he has lots to crow about, or should, but anyway, that's

1 another story.

2 But the thing is, I do want to do what Burt said. If we can somehow make clear in this chapter

3 that this is not the case for many, many kids. There are still barriers, whether they be socially determined

4 or what have you. But I think it needs to be somewhere in the text that there still are problems to access

5 to care, notwithstanding the success of SCHIP and the Medicaid covered kids.

6 CHAIR ROWLAND: Well, and reminding that this is broad national data and doesn't necessarily

7 reflect a situation which we know varies across many of the States.

8 Patty.

9 COMMISSIONER GABOW: Maybe this is in here and I just didn't catch it, but to the point that

10 we're discussing, it would be useful, I think, for me to know, when you try to do analytics like this, what

11 percent of Medicaid children are, in fact, similarly situated to insured children. And if that percent were

12 two percent, that would have a great deal of meaning to me compared to if you said, well, 95 percent of

13 Medicaid children are similarly situated to children who have employee-based coverage.

14 Also, if you did the same thing with the uninsured, to say, well, what percent of these uninsured kids

15 are really similarly situated to the employer-sponsored children, because my assumption, which could be

16 completely wrong, is that the percentage of similarly situated children is very small, and without

17 understanding that variable, it makes this hard to interpret.

18 CHAIR ROWLAND: Well, Patty, even when you do an adjustment so that you are only looking

19 at children who come from families with an income of up to 200 percent of poverty, those that have ESI are

20 healthier and they're more likely to be from the higher end of that income group and the Medicaid children

21 are more likely to be from the poorer families. So even that income adjustment, they're really not similarly

22 situated. They're closer than including kids from families earning $100,000 a year, but they're not the same

23 situation.

1 COMMISSIONER GABOW: But I guess -- I hear what you're saying, but --

2 CHAIR ROWLAND: So maybe using similarly situated is not as accurate as it should be.

3 COMMISSIONER GABOW: If the population sizes are dramatically different, then -- I hate to

4 use this word, but the robustness --

5 [Laughter.]

6 COMMISSIONER GABOW: -- of the findings become, I think, very different. You know, I

7 think we started down this path when we first started discussing it, and well, are they really similarly situated.

8 You know, we know what that definition means in terms of analytics. But do we know what that translates

9 to in terms of percentage of a given population? And I think that's a relevant number, and maybe it's here,

10 but I didn't see it.

11 MR. PETERSON: That's hard to do in this context because, for example, if 52 percent of

12 Medicaid-CHIP children are female, then the average child is 52 percent female, and that's hard to find that

13 child. And when you put a bunch of these characteristics together, what the average is for Medicaid and

14 CHIP, there are a lot of Medicaid-CHIP kids who don't look like the average. And the purpose of

15 regression controls are to control for all of those different factors, as numerous as they are, and so it's

16 challenging, as Diane alluded. Even if you just pick one characteristic, like income, and limit the analysis to

17 that, okay, that gets you closer, but the purpose here was to try to control for a bunch of other factors, as

18 well, simultaneously.

19 CHAIR ROWLAND: Which is why we end up with big residuals when we do regression analysis.

20 Burt. Denise, you had a comment earlier.

21 COMMISSIONER HENNING: Yes --

22 COMMISSIONER EDELSTEIN: Well, for those of us who play in the world of regression

23 analyses, this makes complete sense. Similarly situated is a nice phrase that tells us what we mean. For

1 people using this document, it may not be nearly as meaningful, so here's a potential way out of this pickle
2 that we found ourselves in.
3 Perhaps all we simply need to do is to be very careful in the title and very careful in the set-up of the
4 piece to say, not about regressions, not about similarly situated, but to say that this is an effort to tease out
5 from the data the specific role of having Medicaid coverage versus having private coverage or no coverage.
6 Have it be about the role of having coverage, which is really what the regression allows you to say and what
7 the intent of the chapter is, and focus less on the idea of similarly situated. Then up front, we can say,
8 regression is used to negate or to limit or to dampen the impact of demographic differences so that we can
9 see with the most clarity what the role is of coverage, which is really just restating what a regression does.
10 But for the kind of reader we are addressing here, not talk about it as similarly situated or residuals
11 or controls or anything like that, but put it in the context of teasing out the unique component of Medicaid
12 coverage for these outcome variables. Is that helpful?
13 CHAIR ROWLAND: Mm-hmm.
14 COMMISSIONER GABOW: Yes.
15 CHAIR ROWLAND: Okay.
16 COMMISSIONER EDELSTEIN: And it addresses Patty's issue because, in fact, there isn't -- and
17 Chris's issue -- there is nobody who is 52 percent female and there is nobody who -- we can't really say what
18 percentage of kids actually look like the other and it helps build that argument about the fact that poverty
19 contributes significantly, but even in poverty, we find that having Medicaid coverage is helpful. It's just a
20 better balanced approach.
21 Right now, the two issues are that the title of the piece and the way it is set up initially leaves a
22 misimpression and the piece doesn't have as much balance as it would if we said, okay, now we know what
23 the unique part of -- the unique contribution of Medicaid coverage is, but in real life, these kids are poorer.

1 They do have more complex lives. There are other issues and so there are these ongoing disparities.

2 CHAIR ROWLAND: And they live in very different States and this in no way controls for which

3 State they live in.

4 Denise.

5 COMMISSIONER HENNING: I heartily agree with pretty much everything that everybody said

6 about that particular issue.

7 One of the issues that I had was kind of a structural thing. When we added the methodology

8 overview, which, thank you very much. I think that really was very, very helpful to have that in there.

9 Where it was placed in the chapter didn't really make as much sense to me, though.

10 So I was thinking, like from line 53 through 101, that overview should really be more up front in the

11 chapter. So I was thinking more like I would put it starting at line 37 and move line 37 and our beautiful

12 little figure to be the last part of that before we jump into the different charts and graphs and texts kind of

13 thing, if that makes sense.

14 CHAIR ROWLAND: We'll see if that works.

15 COMMISSIONER HENNING: Just kind of to explain why it is, or what the methodology was,

16 why we did what we did, and then kind of talk about the framework around which we were, you know,

17 accessing information and going to be talking about the information.

18 CHAIR ROWLAND: Okay. And I think you could add to the methodology the fact that it is a

19 national survey so that it can't take into account State variations in policy or coverage as another, you know,

20 an addition to every other caveat you've got here.

21 Other comments or questions. Mark, did you have one? No? Steve, I thought I saw your hand

22 up at one point.

23 COMMISSIONER WALDREN: No. The only thing I was going to add was that if we make the

1 change that Burt mentioned with removing kind of the utility, that we probably should make a small
2 paragraph right after the diagram saying why we're doing that. So we just say, well, look at this lovely
3 model that we have, and then we're going to ignore it for the rest of the chapter, but I assume Chris would
4 probably do that.
5 MR. PETERSON: The reason that I think that would be so valuable is that it's important for
6 MACPAC as a Commission to say, with the available data, we can't sort out the -- we know what the
7 components of access are, but the data do not allow us to sort out the difference between access and
8 utilization -- between availability and utilization, and so more work needs to be done because it's partially on
9 the provider side that it's a problem and it's partially on the beneficiary side that it's a problem, and sooner
10 or later, we have to come to grips with that.
11 CHAIR ROWLAND: Other comments? Okay. So we'll look back at how to organize the
12 methodology section. We'll rephrase how we are describing what the content of this chapter is. We'll put
13 in some additional language around the fact that utilization -- I think we should stay with our framework,
14 but explain that utilization is driven by a lot of other factors, but we have actually got that in the way in
15 which we treated it in our access discussion, so I think we can put those caveats into the draft itself and bear
16 those in mind as we try and do a comparable piece for the next June report on adults that will have the --
17 I'm sure will have many, many similar situations. Adults are even harder because some of them only get
18 onto the program, as we noted, by being disabled, so we have to really look at that adjustment, too.
19 Burt.
20 COMMISSIONER EDELSTEIN: The only one I'd add to the list you just made was the issue
21 about it being family reporting. At least with adults, it's self-reporting. You have social desirability either
22 way.
23 CHAIR ROWLAND: So I thought that was pretty much already here, too.

1 COMMISSIONER EDELSTEIN: It's discussed in the methodology, but in each of the headlines,
2 for example, on page -- there's a very bold statement on page seven, for example. There are a series of
3 such bold statements, or on page six. Nearly all children with Medicaid and CHIP have a usual source of
4 care, okay. I would be more comfortable if it said --
5 CHAIR ROWLAND: Families report that --
6 COMMISSIONER EDELSTEIN: -- families report that.
7 CHAIR ROWLAND: That's fine.
8 COMMISSIONER EDELSTEIN: Similarly, with each of the subsequent bolded titles.
9 CHAIR ROWLAND: Although everything in the chapter is families reporting, so it does also get
10 to be a little redundant. I think you could also make that point very clearly up front.
11 COMMISSIONER EDELSTEIN: It is a bit of a litany, but you can see -- you can see that
12 headline being pulled out of this report and people saying, there is no problem with kids' access. It says
13 right here.
14 COMMISSIONER MOORE: But, you know, we're going to face this --
15 CHAIR ROWLAND: But that's true of anything we do.
16 COMMISSIONER MOORE: -- with every single time we ever use any survey. That would
17 mean that when we get to adults, we have to say people --
18 CHAIR ROWLAND: People report --
19 COMMISSIONER MOORE: -- as reported, blah, blah, blah. I mean, it --
20 CHAIR ROWLAND: I mean, I think as long as it's clear of how the survey is done and who
21 responds and that all of these are footnoted to the surveys --
22 VICE CHAIR SUNDWALL: [Off microphone.] I thought it was pretty clear.
23 COMMISSIONER HENNING: And that's actually a good rationale for putting the methodology

1 a little closer to the front, just to make sure that that's real clear that that's where the information comes

2 from.

3 COMMISSIONER ROGERS: And I think it's pretty clear that when you're dealing with children,

4 it's going to be the caregiver or the family or whoever is taking care of that child is the one giving the report.

5 I mean, that's what makes logical sense --

6 CHAIR ROWLAND: It's going to be true of almost any survey. We will have some people

7 self-reporting and a lot of other surveys, if we get into dual eligibles, any survey there is also going to be

8 based on caregivers and others reporting, so --

9 COMMISSIONER ROGERS: Right.

10 COMMISSIONER EDELSTEIN: Okay. So I just let go of that one, and having let go of that

11 one, I do still suggest that we, without a group effort at wordsmithing, that the title of this chapter be very

12 carefully -- very carefully redrafted to give a better indication of what's really in it.

13 CHAIR ROWLAND: That's fine.

14 VICE CHAIR SUNDWALL: [Off microphone.] Do you want it to say everything but dental

15 care in the title?

16 COMMISSIONER EDELSTEIN: No, it's not that. I want it --

17 VICE CHAIR SUNDWALL: [Off microphone.] I'm just teasing.

18 COMMISSIONER EDELSTEIN: Okay.

19 CHAIR ROWLAND: It's actually a comparison of -- it's the role of Medicaid and CHIP

20 compared to other sources of coverage. Okay. All right. Well, we will wordsmith and go forward.

21 Thanks, Chris. Do you have any other questions for the Commission members?

22 Okay. I think we can move on now to discuss the Medicaid and CHIP financing chapter, so if

23 Chris would relieve his spot to Jim, that would be great.

1 EXECUTIVE DIRECTOR ZAWISTOWICH: He has to hang out for CHIP.

2 CHAIR ROWLAND: Oh, you have to hang on for CHIP. Sorry.

3 ### **STATE MEDICAID FINANCING AND IMPLICATIONS FOR PAYMENT**

4 * MR. TEISL: Good afternoon, everyone, and thank you. So similar to our session on Medicaid
5 and CHIP financing last time, the purpose of this session is to obtain your feedback and guidance on the
6 proposed chapter. And as a reminder, this chapter includes two sections. The first is State financing of
7 Medicaid, the context, scope, and relationship to provider payment. There's also a section providing an
8 update on Federal CHIP financing.

9 I won't go through in detail again everything that's in the chapter, but you see here a high-level
10 outline of the chapter. Some of the key points are that Federal statute provides States with flexibility in
11 financing the non-Federal share of their Medicaid programs, and States vary in their use of general revenue,
12 local government contributions, and health care-related taxes. State financing decisions may affect the way
13 that States pay providers, including their use of supplemental payments and the amount of payments to
14 providers, which in turn may relate to provider participation and enrollee access to service. And a better
15 understanding of both State financing and provider payment would help policymakers identify and
16 implement policies that most efficiently and effectively promote access to both appropriate and high-quality
17 services.

18 Overall, the structure and the content has largely stayed the same in this chapter, but there are a few
19 updates that I want to mention based on your feedback from the last meeting.

20 We did add mention of the fact that during economic downturns, enrollment in Medicaid increases,
21 which may provide an additional challenge to State to come up with the non-Federal share of their Medicaid
22 programs.

23 We tried to address the overall tone by adding additional citations to support some of the

1 discussion, as well as to be clear about the reasons that some of the Federal data, particularly the CMS 64
2 data, may need to be viewed cautiously, both in areas of financing and supplemental payments.
3 We clarified the discussion of the health care-related tax safe harbor and its relationship to indirect
4 guarantees rather than to hold harmless more broadly.
5 We tried to be clear about the fact that supplemental payments may not be directly tied to specific
6 services. So we tried to clarify that we weren't saying that supplemental payments had no relationship
7 generally to Medicaid services enrollees, but that they couldn't be directly tied to specific services in all cases
8 in the same way that claims payments are.
9 We also have begun to incorporate some of the feedback from our State reviewers, and hopefully
10 you saw some of that reflected, as well.
11 MR. PETERSON: And on the --
12 CHAIR ROWLAND: And I would just note that Donna Checkett, who couldn't be with us today,
13 said that she really supported the many changes in this chapter and thought it was much improved from the
14 beginning of our discussion.
15 MR. TEISL: Great.
16 MR. PETERSON: And whereas the Medicaid portion of the chapter provides a lot of new
17 information, really, the Federal CHIP financing part is summarizing and updating what has been provided in
18 previous Commissioner documents, including the MAC basic that we did last September. So that is why
19 the title is what it is and there haven't been really any substantive changes to this portion since the last draft.
20 COMMISSIONER RILEY: I would certainly echo Donna's comments. I think the staff gets
21 kudos for really getting the right balance here. It's an extraordinarily difficult set of issues to understand
22 and I think it's done very, very, very well and real value added to the field.
23 The only two little quibbles I'd have is I think we should be a little bit stronger about -- we show in

1 the charts 2011 data, and, of course, that reflects the enhanced FMAP. So I worry about how this always
2 gets used. This is such a hot issue. You've brought light to all the steam that follows this issue. But I
3 worry that a chart that sticks out and shows so much Federal spending that's an anomaly is a little bit
4 worrisome. So either use a set of years or make that clearer.
5 And again, on the chart, whichever one it was -- Figure 5 -- it's just something that just -- the second
6 -- one of the reasons States have turned to every bit of creative financing that's allowed by law is the
7 countercyclical nature of the FMAP. And it's here, but I would -- I actually was hoping we could do a
8 recommendation on it, but I recognize that may be premature. But I would really give that a heading and
9 make it really clear that that's a serious problem for States, that the FMAP doesn't keep up with the
10 economies of States.
11 So I'm glad it's here. It's a sentence. But I would just really make it much stronger and under a
12 headline.
13 CHAIR ROWLAND: And maybe address it more in the looking forward section as an issue to be
14 dealt with as we go down the road?
15 COMMISSIONER RILEY: [Off microphone.] Yes, right. I meant that.
16 CHAIR ROWLAND: Good. Judy.
17 COMMISSIONER MOORE: I think this is just a great piece of work and I think it could be
18 subtitled something like, "Everything You Always Wanted to Know About State Medicaid Financing,
19 Including UPL, Supplemental Payments of All Kinds, Taxes, and Never Before Were Able to Find in
20 English," so thank you for putting it all in one place and putting it in English. It is still very complicated,
21 but I think it's very nicely --
22 CHAIR ROWLAND: I think the glossary is to really highlighted.
23 COMMISSIONER MOORE: Yes. In terms of the looking forward section, the other thing that

1 I would like to see a little emphasis on if we can figure out how to do it is the need -- and it is mentioned in
2 the chapter, but again, as we go into our next year or so -- is the need for more and better State information
3 on some of these financing relationships and just the ways that we could learn more, because I don't think
4 that we make very intelligent decisions about Medicaid financing, certainly in Washington, when we really
5 don't know very much about what States are doing, which States are doing what.
6 CHAIR ROWLAND: I also think in some of our discussions around this chapter we talked a little
7 bit about all of the variable matching rates that are in the program and the incentives that these different
8 matching rates offer, both on the service side and on the administrative side to do A, B, or C, and that while
9 it's not what we intended to cover in the scope of this chapter, it may be worth flagging that as an area to go
10 forward, that this is one -- if we get into countercyclical financing, we ought to also look at how the
11 financing formula, the FMAP and all the adjusted other formulas, might or might not be either combined,
12 changed, or used, and I think it goes even with our program integrity chapter, where some of those activities
13 are very strongly supported where other activities aren't. So I think we can just raise that at the end as an
14 area where we plan to pursue more work.
15 Denise.
16 COMMISSIONER HENNING: I am definitely not a financing guru, but I just had a couple of
17 comments on line 32 and 33, and I was just wondering if there was some more tactful or politically correct
18 way of stating that.
19 CHAIR ROWLAND: It's page --
20 COMMISSIONER HENNING: And also, we might want to make the point -- it's page five on
21 my draft here. And we might want to make the point that States have to balance their budgets, whereas
22 the Federal Government can run a deficit. I mean, that seems to be an issue for States. At least, I hear
23 about it a lot, like we have to balance budgets. We have to make choices. We only have X-number of

1 dollars that we get. And when the economy goes bad, especially like looking at Florida, our property taxes
2 are pretty much what supports the State budget and our property values have dropped so much that our tax
3 revenues are really low compared to what they were three years ago. And now the Medicaid budget has to
4 go up because we've got more people unemployed, out of work that are accessing Medicaid for their
5 medical care. So it becomes a -- you know, they're between a rock and a hard place.
6 CHAIR ROWLAND: Richard.
7 COMMISSIONER CHAMBERS: I hope I'm not going to repeat anything. I apologize. I had
8 to step out for a minute while you were discussing this, but the whole financing issue is so critical. It's a
9 start in a very tough area that we have spent a lot of time as a Commission talking about. It is at the very
10 core of the Medicaid program and I really think it's a good job of identifying some of the very complex
11 issues and look forward to our continued work, because as all the stuff swirls around in this town and in
12 capitals all around the States, around the country, the financing of the Medicaid program has been and will
13 continue to be such a key issue and, I think, is where we can help sort out some of the myths and the truths,
14 is to be able to influence those discussions will be really critical. So I just wanted to make that comment.
15 CHAIR ROWLAND: David.
16 VICE CHAIR SUNDWALL: I just want to second the compliments. I think this is going to be a
17 huge contribution of the Commission, bringing some transparency to this issue. I was responsible for a
18 Medicaid program, not the director but part of our Health Department, and I learned a lot from reading this
19 chapter. It makes more sense to me than it used to.
20 However, I think the Commission needs to understand that this kind of transparency will cry out for
21 reform. I think that we need to understand that this good contribution is going to have people take notice,
22 and I would be very surprised if we do not see the Commission's work cited, possibly in ways we won't like.
23 But at the same time, I think if we're all in favor, as we've said repeatedly, of streamlining and simplicity and

1 simplification, I think this kind of information is going to bring a lot of attention. But it's necessary and it's

2 what our role is.

3 CHAIR ROWLAND: Well, I think the part of the chapter, the looking forward and the broader

4 agenda, I think that the draft here does not reflect the broader direction that the Commission members have

5 suggested that we have to go to over time.

6 And I think, to Denise's point, you know, one of the pieces is also to look at the fact that States

7 have very different revenue bases, so they're affected very differently by how they both get hit in a recession,

8 but also by their ability to generate additional State revenues to offset other costs.

9 Other comments?

10 [No response.]

11 CHAIR ROWLAND: Okay. Well, we recommend that you go forth and make appropriate

12 revisions on this part, and no comments on the CHIP part. And I clearly think that there's a lot of

13 differences between the financing issues when we look at Medicaid and the structure and the financing

14 issues for CHIP, and as we go forward to really look at CHIP in the future and reauthorization, the

15 interaction with the ACA, and the financing issues that will come up and revisit many more of those issues

16 again.

17 Okay. Thank you. All right. So we're going to take -- we've gotten to our break time. We've

18 moved expeditiously through our material, so let's take a ten-minute break and then come back to complete

19 our work.

20 [Recess.]

21 CHAIR ROWLAND: If we can start to get serious about reconvening, please.

22 [Pause.]

23 CHAIR ROWLAND: As we turn from the chapters to MACStats, I just want to say to the

Commission members that their diligent reviews and their thorough comments on the chapters back with very little turnaround time from when they received them is commendable, and I think that the staff discussion today has been easy because we've had such a great turnaround from the staff of the comments that have come in from the Commission members. And I think that they've come together so that fortunately we weren't all on different places from the comments that we were submitting. So I think this has been a great experience for all of us to get this set of chapters really together. It's a little different than what we went through last year when we were new and green and didn't know each other. But I really do appreciate the fact that every one of the Commission members has been so responsive to taking time to review things, the initial conversations that we had with group leaders, taking the comments and trying to figure out how to put things together, have all worked out very, very well. So thank you and, you know, continue to look and do this and harass the staff whenever necessary.

[Laughter.]

CHAIR ROWLAND: But this I think really has been a very productive set of reviews, and I think we're in really good shape with these chapters.

The final part of any report and this piece in March that has come to be -- I can't tell you how many times the Hill says, "This is just great." I think they don't -- I'm not sure how much the text is read, but the numbers are looked at, and so we wanted to turn to April and Chris to take us through the MACStats piece of our March report, and then we'll go on for some comments from there.

UPDATE ON MACSTATS

* MS. GRADY: Thank you, Diane.

I've got some animation here. We're going to talk today about the MACStats for the March 2012 report, and as we discussed in January, the MACStats for this March report largely follow the order and the content of last year's report. We have added some new information to support this year's chapters, the

1 March chapters, and all of the data are updated to reflect the most recent year available.

2 Now, today I want to walk you through the issue areas just to be sure we're all familiar with the
3 topics that are covered this year, which, again, are very similar to last year. I apologize here. The first
4 area that we'll talk about in MACStats is enrollment, and we have several tables that deal with both Medicaid
5 and CHIP enrollment.

6 As I go through these slides, I won't read through all of the tables here, but I will highlight some key
7 points to be aware of, changes and interesting things to note since last year.

8 In the January meeting, we had noted we hoped to expand the information provided in Tables 1 and
9 2 which deal with Medicaid and CHIP enrollment as a percentage of the U.S. population and also some
10 state level Medicaid information. But we're unable to add this new information in part because the data
11 aren't available in time for the March report deadline, so we'll circle back to see if we can include that
12 expanded information in June instead. But, again, the base content of Tables 1 and 2 will be the same as
13 last year updated to reflect the new information, just not expanded.

14 The second issue area for MACStats that we cover is spending information for Medicaid and CHIP,
15 and with regard to Medicaid spending, one thing to note that Trish brought up in our last session is that
16 there was a temporary increase in Federal matching dollars for several years that began phasing down in
17 fiscal year 2011, so that's one difference that you would see in comparing the Medicaid spending that we
18 showed in MACStats last year for fiscal year 2010 compared to this year, fiscal year 2011, that the federal
19 share will be phasing back down.

20 Another major area that we cover in the MACStats is income eligibility for the program, covered
21 benefits, and cost sharing. One thing I would point out here, as you know, states are subject to a
22 maintenance of effort on eligibility for most populations, so any changes in eligibility that you'll see are likely
23 to be increases if there is any change at all.

1 Moving on to some other key issues, sort of our catch-all bucket here for the MACStats, here we
2 cover a range of issues. Again, FMAPs in Table 14, as we mentioned, there was a temporary increase that
3 phased down in fiscal year 2011, and what we do in this table here is to show how state FMAPs have
4 fluctuated since fiscal year 2008, which was before the temporary increase began, and then bring it through
5 fiscal year 2012, where states are back at their regular formula levels, to see the change that has occurred
6 before, during, and after the temporary increase.
7 The other thing I would call your attention to on this slide is Table 19, income as a percentage of the
8 federal poverty level for various family sizes. One of the things we do a lot in our work is to talk about the
9 FPL, percentages of the FPL, in a sort of abstract way, and this table actually provides the dollar amounts
10 that you can connect back to those FPL levels, where we don't always include that dollar amount in the text
11 of a chapter, for example. And just to point out that in 2012 for a single individual, 100 percent of the
12 poverty level is $11,170, just for a point of reference.
13 The table breaks out the poverty levels in the lower 48 states and also Alaska and Hawaii, where they
14 do differ slightly.
15 The final area, which is new for this year, this March report compared to last year, are some
16 additional tables in support of the Medicaid and CHIP financing chapter. We did talk about these with
17 you in January. Again, Jim has pointed out that supplemental payments are a substantial share of total
18 spending on certain types of providers, including hospitals, I believe about 40 percent overall. But what
19 this table and MACStats is showing is the state variation in the use and amounts of these supplemental
20 payments, so that's the additional level of detail that MACStats provides.
21 One thing I would point out that Jim mentioned is that the supplemental payment data are newly
22 reported as of fiscal year 2010, so we have taken care to caveat the fact that these are newly reported
23 expenditures, and CMS is working with states to standardize the reporting of that information.

1 We also are showing provider taxes by state. We are also caveat'ing that information because the
2 provider tax data, there's some indications that it's underreported, and we want to be careful about, you
3 know, presenting information and giving context for that information. They may be underreported in part
4 because it's a voluntary form. It's not something that affects Federal reimbursement received by states.
5 So, again, we want to present this information in context and note any possible caveats. And as we
6 covered before, there are also some additional state-level tables, federal CHIP allotments, and CHIPRA
7 bonus payments.
8 I'm happy to answer any questions that you might have about the MACStats.
9 COMMISSIONER RILEY: This is a joint question. This is a sidebar. Obviously, given what
10 we just went through with the paper that's now terrific, I'd be cautious about the taxes, but I would not say
11 anything about any underreporting. It's not factual. It's an assertion, it's hearsay. So I would just let
12 that go and not talk about it in the narrative or in the chart.
13 CHAIR ROWLAND: The other half of the question [off microphone].
14 COMMISSIONER COHEN: No, no -- I mean, just to make the point, I mean, if there's like a
15 factual basis to say it, that's one thing. But, you know, if it is sort of like rumored or -- you know what I
16 mean? There has to be a basis to say it in order to say it because it is obviously--
17 MS. GRADY: Sure. In the rule on health care-related taxes that CMS put out several years ago,
18 they did indicate that this particular data source may be underreported, that states may underreport on this
19 particular form. So there is some evidence for that. We are in communication with CMS about these
20 data and, you know, we'll provide appropriate context if there is a basis for it.
21 COMMISSIONER RILEY: And check with NAMID [phonetic] as well, I would say.
22 VICE CHAIR SUNDWALL: April, could you save me the work of looking at the data and give us
23 some trends from last time? Other than increased enrollment, is there anything exciting that stands out

1 from these various tables?

2 MS. GRADY: I think the issue that I did highlight, which is the return to regular federal matching

3 rates after a temporary increase, that would be the key issue that I would highlight, again, throughout,

4 where, you know, total spending is still growing for Medicaid as enrollment grows and health care inflation,

5 you know, continues. But the composition of the total spending is shifting to be more heavy on the state

6 side as those matching rates are declining back to their regular levels.

7 CHAIR ROWLAND: April, earlier this year or late last year, the Census Bureau put out new

8 measures of ways to look at poverty and some state adjustments there. Are we planning to do any analysis

9 of the state variation in what the cost of living is?

10 MS. GRADY: That's not something that we've discussed with you to date, but it's a possibility.

11 We haven't specifically reviewed that information to date.

12 EXECUTIVE DIRECTOR ZAWISTOWICH: Do it for June?

13 CHAIR ROWLAND: Yes, that would be useful to do for June, because I think it gets into issues

14 of why a state like New Jersey might have a CHIP rate of 300 percent of poverty for their eligibility

15 compared to another state that's at 200, because the cost of living varies so widely, and that's something that

16 hasn't actually ever been taken into account in the federal poverty level.

17 Other comments?

18 [No response.]

19 CHAIR ROWLAND: Was Chris going to talk?

20 MS. GRADY: That's it.

21 CHAIR ROWLAND: That's it. Okay. Thank you very much.

22 MS. GRADY: Thank you.

23 CHAIR ROWLAND: So certainly for April, which is our next meeting, we will have put this

1 report both to bed and to the Congress, and hopefully it will be used as something other than bedtime
2 reading. I hope that it will take us the next step of laying out some critical issues around the population
3 with disabilities that is a key population in the Medicaid program and one that we think warrants much
4 further examination and work, also to continue to look at the financing and especially the payment and
5 access issues. But that will be sort of getting us to discuss our June report and then to really lay out a
6 broader analytic agenda.

7 At this point in our meeting, we do welcome any comments that anyone in the audience may choose
8 to make as part of our public record. Do we have anyone who wants to come to a microphone that is in
9 the middle of the room?

10 Do any of the Commission members have any closing comments to make, as well?

11 Do you have a comment, Suellen? And for the record, just identify yourself.

12 ### **PUBLIC COMMENTS**

13 * MS. GALBRAITH: [Off microphone.] I'm Suellen Galbraith with ANCOR. We're a national
14 private provider association, and it's very informal [inaudible].

15 But I am so thrilled with the attention that you are bringing to this important area regarding people
16 with disabilities, examining, putting forth, and it is a very heterogeneous group. The financing issues,
17 quality measures which we do not have, and particularly in the area of long-term services and supports. I
18 just can't thank you enough. And again, the quality measures.

19 So thank you all so much. This is going to be a major contribution. I appreciate it --

20 CHAIR ROWLAND: Thank you.

21 MS. GALBRAITH: -- that you're focusing not on just the duals, that you are looking at what's
22 going to happen with the rest of the Medicaid older population. So thank you very much.

23 CHAIR ROWLAND: Thank you.

1 Any other compliments or comments?

2 [Laughter.]

3 CHAIR ROWLAND: Robin.

4 COMMISSIONER SMITH: I just want to, again, thank our staff because they are just amazing.
5 I'm blown away every single time I come up here and see the amount of work you've done, so thank you.
6 You make us look good.

7 CHAIR ROWLAND: Richard.

8 COMMISSIONER CHAMBERS: I just wanted to echo what Robin said. It is amazing work.
9 It just amazes me how fast you turn around comments that we have, which are voluminous, and as you see
10 us in process, we are a herd of cats and you do a great job of turning it into something that is recognizable
11 to our audience, so thank you very much.

12 CHAIR ROWLAND: And they manage to integrate all of our comments as if they were
13 consistent.

14 COMMISSIONER CHAMBERS: Exactly.

15 [Laughter.]

16 COMMISSIONER CHAMBERS: And thanks to Lu, particularly. Thanks.

17 CHAIR ROWLAND: Other comments?

18 [No response.]

19 CHAIR ROWLAND: Well, with that, in a very expeditious way, we've concluded our work for the
20 day so that the staff can get right back to work and polish up the report so that we can get it off to a printer.
21 But remember, Commission members, if you have any last-minute thoughts or additions that you want to
22 make to the materials for this report, please get them to the staff by Tuesday morning, which means no rest
23 for the weary on the staff, but they might get a weekend --

1 EXECUTIVE DIRECTOR ZAWISTOWICH: [Off microphone.] No, they're not --

2 CHAIR ROWLAND: No, they're not getting a weekend, I'm told. Okay.

3 The other thing I wanted, though, to put forth for you all is that as part of our April meeting, we
4 really do want to look at what policy issues we should be tackling, what our short-term analytic agenda and
5 our longer-term analytic agenda is. We've raised a lot of issues, looking at maternity care. We know that
6 with our responsibilities with MedPAC, we have to begin to also look at the dual eligible population. We
7 also know that we need more work on the disability population.

8 So for each of us, please think through, if you were going to say, these are the two top priorities that
9 you think MACPAC should be addressing over the next year, and then keying up to do two and three years
10 down the road so that we can begin to have a track record on some of these issues, what would they be. I
11 know we need to look at CHIP. I know we need maternity care.

12 But let's lay them all out so that in our April meeting we can really begin to give the staff some
13 guidance so that they don't have to do everything from meeting to meeting, but they can begin to have some
14 work that they're developing over time, working with others outside of the direct staff to begin to build a
15 broader agenda.

16 So travel well back to your locales. Think hard on this report, but especially on where we should
17 be going forward in the future. And I thank you, and the meeting is adjourned.

18 * [Whereupon, at 3:17 p.m., the Commission was adjourned.]