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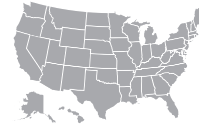

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

Tuesday, May 22, 2012
10:36 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
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JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH
STEVEN WALDREN, MD, MS

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1 P R O C E E D I N G S [10:36 a.m.]

2 CHAIR ROWLAND: If the Commissioners could please reconvene.

3 We want to welcome you to this morning's session of the Medicare and CHIP Payment and Access
4 Commission and we're really pleased to be able to start this session with a presentation by Sean Cavanaugh,
5 the Acting Deputy Director of the Center for Medicare and Medicaid Innovation. We're very interested in
6 the innovative projects that may be coming forth and how to really take into account in our analysis and in
7 our work what the administration is seeing as innovations on the ground and to know a little more about
8 when we can expect to get some of the results from some of the projects that you're launching.

9 So on behalf of the Commission, Sean, we're pleased you're here and thank you for joining us and
10 we look forward to your comments.

11 **#### CENTER FOR MEDICARE AND MEDICAID INNOVATION: OVERVIEW OF**
12 **MEDICAID-FOCUSED DEMONSTRATIONS**

13 MR. CAVANAUGH: Thank you very much for having me. It's a pleasure to be here today and I
14 appreciate the opportunity to update the Commission on the work of the Innovation Center. And I bring
15 the apologies of Rick Gilfillan, who could not be here with us today, but he does look forward to meeting
16 with the Commission and working with you in the months and years to come.

17 As you heard, I'm Sean Cavanaugh. I'm the Acting Deputy Director for Policy and Programs at
18 the Innovation Center at CMS. Today, I would like to tell you how the Innovation Center at CMS, tell you
19 about our mission, how we work, and how we fit into the larger transformations initiated by the Affordable
20 Care Act. I'm going to try to highlight the areas where we're focusing on Medicaid and CHIP populations
21 and I'll be relatively brief to leave plenty of time for your questions.

22 So in many ways, the Innovation Center is a continuation of the work that CMS has always done
23 through the Office of Research and Demonstrations. And, in fact, that old Office of Research and

1 Demonstrations is now part of the Innovation Center, but there are some important differences. Here on
2 this slide, I've quoted from the Section 3021 that created the Innovation Center. But I wanted to highlight
3 some of the differences between the authority that CMS used to have and the authority it currently has.
4 First and foremost, I think it's important the Congress has largely allowed CMS the flexibility to
5 define the demonstration and research agenda going forward. That was not always true in the past.
6 There continue to be mandated demonstrations, but there is a significant amount of funding and flexibility
7 to define an agenda. The statute does include recommendations for us to consider different models and
8 we take those recommendations seriously, but we ultimately have the responsibility to define a portfolio that
9 has the best chance of meeting our statutory mandate.
10 Second, we're no longer subject to budget neutrality in each year of a demonstration, which was a
11 constraint on prior demonstrations. And to help us with that flexibility, we have $10 billion of funding
12 from fiscal year 2011 through 2019.
13 And third and perhaps most important, and mentioned on this slide, is if CMS proves that a new
14 model reduces costs and improves quality, the Secretary has the authority to expand the model through
15 rulemaking, even possibly taking it to a national scale, without going back to Congress for new statutory
16 authority. And that's a very significant expansion of the authority CMS has.
17 I would note here, as I go through my presentation, Section 3021 created the Innovation Center, but
18 as I mentioned, we absorbed the Office of Research and Demonstrations, so some of the models we run are
19 under the 3021 authority that I just described, but some are under other authorities defined in the
20 Affordable Care Act, and I'll try to highlight that along the way.
21 Before I go through our portfolio in detail, I'd like to say a few remarks about how the portfolio was
22 put together and how it continues to evolve.
23 First and foremost, and I think this is the most important, we don't feel that CMS or HHS has all

1 the answers on what the health system needs. We've been very conscientious and made an enormous
2 effort to go out around the country and listen to patients and providers about what works, what doesn't
3 work, and what people would like to do and what their obstacles are. We've had numerous listening
4 sessions and open door forums. We have a website where we've received literally hundreds of ideas.
5 Back in January, we co-hosted a Care Innovation Summit here in Washington, D.C., where over a thousand
6 people from around the country came and exchanged ideas about innovations. So, again, we're trying to
7 take ideas from the field and create models in which people can test those ideas.
8 And the other important thing about our portfolio is we're trying to meet providers where they are,
9 meaning there's enormous variation in the capacity and willingness of providers to transform how they
10 deliver care and we're trying to provide models so that no matter where providers are along that spectrum,
11 they have an opportunity to participate in one of our models.
12 Having said that, I'll walk you through, and I'll try not to spend too much time. We have quite a
13 few things underway, but I'll try to hit the highlights of our portfolio.
14 First, we have a suite of activities around primary care transformation. And again, even within this,
15 there's a range of things to meet providers where they are. The Comprehensive Primary Care Initiative is a
16 multi-payer initiative that's just being launched. This will be in seven markets. It will have an enhanced
17 contribution to the transformation of primary care. The seven markets are about to be announced, and in
18 a couple weeks, we'll be soliciting providers to participate in this.
19 I should note, in this -- as I promised, I'll try to highlight the Medicaid features -- in this, the
20 Innovation Center has offered to States to make the enhanced payments on their behalf to help test this
21 model for any Medicaid fee-for-service beneficiaries who are in the model.
22 We have an FQHC advanced primary care practice demonstration where in 500 FQHCs around the
23 country in 22 States we're making enhanced payments to help them become primary care medical homes.

1 You may be familiar with the MAPCP model, which is another multi-payer model. And again,
2 States in these models are required to have beneficiaries -- Medicaid fee-for-service beneficiaries --
3 participating.
4 I mentioned Independence at Home and the GNE demonstration are two mandated
5 demonstrations from the Affordable Care Act. Independence at Home is working with 16 medical
6 practices around the country to test the effectiveness of delivering comprehensive primary care at home for
7 Medicare patients with multiple chronic disease. And the GNE demo is providing funding for schools of
8 nursing working with hospitals and other groups to train advance practice nurses.
9 Again, in the Accountable Care Organizations, I imagine many people are now familiar with this
10 model, but it's essentially groups of providers who come together to accept the full clinical and financial
11 responsibility for a defined population. And here, we've again tried to provide a range of options so that
12 providers, no matter where they are in the stage of transforming their clinical model, can participate.
13 At the leading edge of it is the Pioneer ACO Model. This is for organizations that are already
14 functioning as ACOs, either in their Medicare Advantage or commercial markets, and this offers them
15 higher levels of financial risk, both on the upside and the downside. And the purpose of this is to test and
16 have these organizations show what is possible. So these organizations were out January 1. There are 32
17 of them around the country, to demonstrate to other ACOs what is possible in improving care and reducing
18 costs. But they are accepting a higher level of financial risk, as I mentioned.
19 For organizations that aren't as far along or aren't as ready to accept such financial risk, the Medicare
20 program has the Medicare Shared Savings Program. I list it here. It's not part of our portfolio, but it is
21 something that CMS is running, and many of the organizations participating in that are new to the ACO
22 model and some not ready to accept downside financial risk. But we got quite a strong response in April,
23 and in July, there will be another batch of ACOs ready to start. And then after that, every January 1,

1 organizations can enter as ACOs.

2 And then for smaller physician-led and rural organizations who feel like this is the right model for

3 them and they feel like they could make improvements if they had the capital to make investments in care

4 coordination infrastructure, but because they're small and physician-led or rural they don't have access to the

5 capital, we have something called the Advance Payment Model. And in this model, the Innovation Center

6 is going to provide up-front financing to the ACO to help them get started. But down the road, when they

7 start generating shared savings and earning money back, they will repay these monies to the CMS.

8 And I mentioned on the slide, there is still the Physician Group Practice. There is still six or seven

9 of those organizations who are finishing up the last year of that model.

10 I'm sorry. I wanted to go back to highlight Medicaid. In the Pioneer ACO Model, one of the

11 requirements of participating is that the organizations get what we call outcomes-based contracts, so

12 something similar to the contract they have with Medicare, meaning being held responsible for clinical

13 outcomes as well as total cost of care, and they need to get similar contracts so that more than half of their

14 business is under such a model. And many of them are interested in working with their States, and we

15 know in Detroit and New York and several other places they've been working with their State Medicaid

16 programs to get similar contracts, particularly around duals but also in Medicaid fee-for-service.

17 We're also offering four tracks for providers to test new models for improving care through

18 bundling. These are events that typically start around an inpatient hospitalization, and so Model 1 is really

19 a gain sharing model where physicians and the hospital can work together to reduce costs around an

20 inpatient admission, and we'll be announcing in the next couple weeks the hospitals around the country that

21 will be participating in that model. Models 2 through 4 bring in post-acute care and readmissions and a

22 broader spectrum of services, and the applications to participate in Models 2 through 4 are due later this

23 summer, I believe at the end of June. These are Medicare focused.

1 One of the missions we take seriously at the Innovation Center is not just to test new models, but
2 also to create infrastructure so that when successful practices are identified, they can be diffused and spread
3 pretty quickly, and we've got a number of efforts underway to do that, to increase the capacity to spread
4 successful models.
5 Our biggest effort is the Partnership for Patients. This is more of a campaign than a model and it's
6 a campaign to reduce hospital-acquired conditions by 40 percent and readmissions by 20 percent. And it's
7 important that both of those goals are not payer-specific. This is across the board, Medicaid, Medicare,
8 commercial. And in that respect, we are working not through our payments systems necessarily, but we
9 have engaged with 26 what are called Hospital Engagement Networks which are groups of hospitals around
10 the country that are working together, over 4,000 of them who have committed to trying to achieve these
11 goals and are meeting regularly and exchanging best practices.
12 One of the activities that we are funding that is specifically helping one of those goals is the
13 Community-Based Care Transition Program, which was mandated by the Affordable Care Act, and that's
14 where CMS is providing $500 million to community-based groups who are cooperating with hospitals and
15 other providers to create interventions that will reduce preventable admissions. Again, none of those are
16 payer specific.
17 Briefly, we also have the Million Hearts Campaign, which is a campaign we're partnering with CDC
18 on where we're seeking to prevent a million heart attacks and strokes in the next five years through
19 community prevention and clinical care improvement. Currently, that really entails bringing some of the
20 proven strategies that CDC has identified and integrating them into the models we already have. But we
21 also expect in the future to have specific models that further the Million Hearts Campaign.
22 The Innovation Advisers is a small program that we hope to grow in the future where people from
23 around the country who are working in health systems have come together with CMS and trained in quality

1 improvement and how to produce interventions that reduce total cost of care, and now they're out in the
2 field implementing these interventions in their health systems around the country. And we're working with
3 them to identify how they can have ongoing relationships with other models that we're doing as advisors
4 and consultants, but also, again, the primary purpose is to take best practices and diffuse them.
5 And the Health Care Innovation Challenge, I actually will touch on in my last slide.
6 We do have a couple interventions that are very specifically targeted on the Medicaid population.
7 The first two of these were mandated in the Affordable Care Act. The Medicaid Emergency Psychiatric
8 Demonstration is going to be in 12 States. We'll be providing $75 million over three years to these States
9 to enable private psychiatric hospitals to receive Medicaid reimbursement for the treatment of psychiatric
10 emergencies. Typically, these patients would be subject to the IMD exclusion. So that is up and running,
11 as I said, in 12 States.
12 And also in another ten States, we're providing $100 million for Medicaid incentives for the
13 prevention of chronic diseases. And the innovation in this model is not the interventions that the States
14 are using. They're actually using evidence-based proven models around tobacco cessation, diabetes
15 prevention, and other areas. But some of the money we are providing to the States is being used to test
16 how do you provide incentives to the patients to comply and participate in these models, and we're testing
17 whether that will improve outcomes in that respect.
18 Lastly in this area, we have the Strong Start for Mothers and Newborns, which is not a mandated,
19 it's a model that the Innovation Center has developed in cooperation with our colleagues at CMCS and
20 others throughout CMS, and it's really two complementary initiatives. One is building on the Partnership
21 for Patients. We're starting a campaign to help reduce early elective deliveries around the country, defined
22 as elective deliveries before 39 weeks. But the funding part is in component two, where we'll be testing
23 three models of enhanced prenatal care around the country and specifically trying to reduce preterm births

1 for women covered by Medicaid who are at risk for early birth.

2 We have, as you know, several models around Medicare and Medicaid enrollees. I understand
3 Melanie Bella was here at your last meeting and went into these in some detail so I won't bother you with
4 the details here. I would just note that these are all models that are done in partnership between the
5 Federal Coordinated Health Care Office and the Innovation Center. They utilize the authority that we
6 have under Section 3021 and we consider them very important parts of our portfolio.

7 And lastly, I'd just like to tell you about the Health Care Innovation Awards. I don't know if
8 you've heard of this. This is important in several respects. At the outset, I mentioned that we don't have
9 -- we have the flexibility to define our agenda, largely without interference. And we've taken what we've
10 heard throughout the country and developed the models that I've described before, and we'll continue to
11 develop models based on what we've heard. But we also wanted to open the door and really allow people
12 to come forward with models that maybe aren't ready for large-scale testing but they're very promising in
13 and of themselves.

14 So we had this open solicitation in January, and just two weeks ago, we announced the first batch of
15 awardees, 26 awardees who received $123 million. We are very pleased. We had an enormous response
16 to this, with close to 3,000 applications coming in. It's partly why we're running a little late in announcing.
17 But in the next few weeks, we'll announce the next awardees.

18 This is important in two respects. One, we've really thrown open the doors and allowed the
19 provider communities to define innovation.

20 But second, we're very pleased to see many of these are focusing on the Medicaid population and
21 CHIP populations. We have a focus on pediatric populations, several focused on behavioral health issues.
22 We have details on the first awardees on our website that you can go check out. But when we do the
23 second batch of announcements, which, as I said, will be in June, you'll see another significant presence of

1 Medicaid and CHIP initiatives. And so we are pleased with that.

2 I've run through quite a bit of material fairly quickly, and I apologize if I was too cursory. But I did

3 want to give you a sense of the breadth of our portfolio and to highlight and so you are aware of some of

4 the things we are doing for Medicaid and CHIP populations.

5 But I'm going to conclude now, because I imagine the Commissioners have many questions, so

6 thank you.

7 CHAIR ROWLAND: Thank you, Sean.

8 Questions? David.

9 VICE CHAIR SUNDWALL: Well, thank you very much for your presentation. First of all,

10 we're really interested in the Innovation Awards, those of us who applied. I don't know if there was

11 anybody who didn't. You had so many applications. Even though you didn't give us one of the first

12 awards, we're anticipating the second or third wave.

13 My question is that when you started off, you had so many initiatives that are primary care based,

14 primary care payment initiatives, demos, all sorts of things related to that. How much of a barrier do you

15 experience with the relative dearth of primary care providers? I find this focus welcome because I've long

16 been a primary care physician, but I come from a State that has among the 44th lowest ratio of doctors to

17 population and a real significant shortage of primary care. Do you sense this as a barrier or not to your

18 initiatives?

19 MR. CAVANAUGH: It hasn't been a barrier to us doing our initiatives, but you have to

20 remember, our initiatives are tests of models. It could be a barrier if these prove successful and we try to

21 take them larger, meaning if these interventions or something along these lines are the solution or a big part

22 of the solution, the fact that we have a shortage of primary care will become, as you know, a problem.

23 What we like to think is that the way these are structured is, one, we're enhancing the attractiveness

1 of primary care as a field, and through the GNE demonstration, enhancing the availability of primary care.
2 But we do think that the availability of primary care and the range of the types of providers is an important
3 consideration. So that hasn't hindered our ability to test the models, but it is something we're very aware
4 of.

5 CHAIR ROWLAND: Sara.

6 COMMISSIONER ROSENBAUM: I'm wondering whether any of your areas of focus are
7 concentrated on the problem of States -- State Scope of Practice Acts. There's, of course, this very
8 difficult scenario that developed between insurers and scope of practice laws where, essentially, scope of
9 practice laws don't change and then insurers, of course, align their payment policies to restrictive scope of
10 practice laws and then there's a, you know, a sort of effort to move scope of practice laws, but then it takes
11 insurance a long time to catch up, even where you're getting a broadened vision of who can engage in what
12 kind of practice.

13 And it seems to me that this whole issue of substitution or an expansion of who's authorized to do a
14 whole variety of things in health care, it ought to be sort of front and center for CMS because both the
15 Medicare and Medicaid programs are so dependent on how States align health care practice authority, and I
16 wonder whether any of your demos are trying to incentivize some changes.

17 MR. CAVANAUGH: You raise an excellent point and it's something we've thought about in a
18 broader context, which is so scope of practice, I think, is one of several areas where States have
19 opportunities and tools that aren't available to the Federal Government. And like I said, it's just one. I
20 mean, we could go through a whole litany, CON and all sorts of things that, properly used, could be
21 powerful tools for improvement.

22 And we have recently been giving quite a bit of thought of how do we engage with States to use not
23 just scope of practice, but certainly scope of practice, but all the other levers that they have that we don't

1 have, and how do we bring synergy between what we're trying to do in the States, and we've been engaged
2 with State groups. So it's something seriously under consideration and I would imagine at some point in
3 the future you would see us doing a model around trying to leverage the opportunities that States provide
4 that the Federal Government doesn't have.

5 CHAIR ROWLAND: Sean, to what extent are the applicants for these various demos community
6 groups, provider groups, versus the States themselves? I mean, we know the duals demos are a different
7 situation.

8 MR. CAVANAUGH: So each model is different. I'll try to quickly go through. I mean, in the
9 ACO models, it's all provider groups. But if you take, for example, the Strong Start Initiative, I think it
10 could be provider or State applicants or them working together. Often, when the State is not a direct
11 applicant, we require -- so, for example, in the duals and nursing facility demo, the applicant is not the State,
12 but the State has to write a letter of support in order for you to be qualified.

13 So we're very conscious of when you're dealing with Medicaid and CHIP populations that there's
14 this three-party, you know, the patient, the providers, the States and the Federal Government, and we're
15 trying to strike the right balance of involvement and support.

16 VICE CHAIR SUNDWALL: Sean, just to follow up to that question real quickly, I understood
17 that on the Innovation Grants, States were precluded from participating. State Health Departments could
18 not apply for that.

19 MR. CAVANAUGH: Yes.

20 VICE CHAIR SUNDWALL: So it left them kind of handicapped. You say a number of those
21 awards deal with Medicaid and CHIP, but it's certainly not through Medicaid programs or State Health
22 Departments, right?

23 MR. CAVANAUGH: You are correct. States in that one model -- in that model could not be the

1 actual applicant. However, I mean, many of the applicants are targeting new interventions that are
2 specifically trying to improve care and reduce costs for Medicaid and CHIP.
3 VICE CHAIR SUNDWALL: I would just posit that was a real problem for some of us and would
4 have liked to have been able to do it from the State perspective, too.
5 CHAIR ROWLAND: Okay. I have Denise, then Judy, then Patty, and then Trish.
6 COMMISSIONER HENNING: As a certified nurse midwife, my focus mainly is on women's
7 health, and somehow in the Affordable Care Act, at the last minute, nurse midwives and OB/GYNs were
8 dropped as being primary care providers, so we're not eligible for the bump-up. But I would postulate that
9 for a woman, we really are her primary care provider, and especially a certified nurse midwife who is not a
10 surgeon, who is mostly taking care of reasonably healthy pregnant women and women doing annual
11 well-care visits. I mean, there's nothing more primary care than that. So we have that problem.
12 And then we have another problem in that we were happy to see that CMS is encouraging the
13 granting of hospital privileges to certified nurse midwives, but we really could use them to go a step further
14 and say, you know, it's just not right to deny hospital privileges based on the fact that you're a certified nurse
15 midwife. There are many of us across the country that can't get hospital privileges only because the
16 OB/GYN section, the doctors that control who gets privileges and who doesn't, don't want the
17 competition. Now, we all know that that's against Federal trade restriction rules, but you have to have
18 money to fight that.
19 So if CMS would say, this is not allowed, that is not under the conditions of participation, if you
20 want to take Medicaid and Medicare money, you have to allow privileges to people that are licensed in your
21 State to be able to take care of patients -- most births happen in hospitals these days. So if you can't get
22 hospital privileges, you are out of business, and it's purely a business thing.
23 So we could use CMS to be in our corner just a little bit more. I mean, I'm glad that they're

1 heading in that direction, but I think that we really need a clear, straightforward statement, because
2 otherwise we're just not going to be able to stay in business.
3 CHAIR ROWLAND: Sean's team needs to do a demo that proves your point.
4 [Laughter.]
5 MR. CAVANAUGH: So thank you for those comments and I will take it back to our team. I
6 mean, we clearly have a team that cares quite a bit about women's health and perinatal care, so I will bring
7 your suggestion back. And I do believe under the authority of the Affordable Care Act that we could try
8 something on the conditions of participation.
9 CHAIR ROWLAND: Okay. Judy.
10 COMMISSIONER MOORE: Hi, Sean. Thanks for coming.
11 I spent a full career, a number of careers at the CMS and around the Department and have --
12 primarily involved in the Medicaid program -- and have lived the life of exclusion from a lot of the research
13 and innovation that went on, at least in the past, and I am hopeful that you all are taking a bit of a different
14 approach now with the Innovation Center. I've always understood Medicare is much easier to deal with
15 from a research perspective. It has data, among other things. It isn't 50 different programs.
16 But I would urge you to think about the populations served by Medicaid and perhaps try to -- and
17 this Commission has tried to do that, particularly around children. You know, a third of the kids in this
18 country are covered under Medicaid. Around births -- in some States, it's 50 percent of the births are
19 covered by Medicaid. Disabled people -- we have felt on this Commission that the disability population
20 wasn't necessarily being -- having as much attention paid to them as they should.
21 And maybe in your efforts around model spreading, for example, development of models and
22 spreading them, you could think of the Medicaid population as you continue to refine your policy
23 approaches and so forth. But I wondered if you had done any of that.

1 And I guess the last thing I would say is Medicaid is a very operational program, both at the Federal
2 level and at the State level, and there's a very, very hard fit with research for that because the people who are
3 running Medicaid programs are always doing fire drill kind of activities. They don't have the expertise or
4 the background to do the research kind of activities. Although they're interested, they just don't have the
5 time and they don't have the resources.
6 So I think there are some opportunities for you all to define a new way of communicating between
7 the research community and the operational community and I hope you'll be able to do that.
8 But I guess after my little speech here, my real question is the extent to which you think you could
9 look broadly at the Medicaid populations and the needs of those populations beyond the duals, which we
10 understand you're involved in, and other ways, and develop some initiatives and some innovative
11 approaches around the areas that you have but also serving the Medicaid population to a greater extent.
12 MR. CAVANAUGH: So thank you for your comments, especially the ones about linking the
13 research and operational communities. I would like to, at some point, talk to you more about that because
14 it is very interesting.
15 But specifically around our involvement in the Medicaid populations in our portfolio, your points
16 are well taken and I do -- it is a different set of opportunities and challenges when we try to do something
17 through Medicare as opposed to Medicaid. You know, we feel like with the duals, we've taken on quite a
18 challenge, but we don't feel like that's the whole Medicaid population and there's still lots of needs and lots
19 of opportunities. You'll see plenty in the Innovation Awards, but you will also see -- I mean, we are going
20 to continue thinking, and I think you will see in the coming years that our -- the balance in our portfolio will
21 involve a lot more in Medicaid, and we've benefitted greatly from collaboration with our colleagues, Cindy
22 Mann and her team, and Melanie and her team, who have made us sensitive and identified opportunities for
23 us. So I would just ask you to stay tuned and I hope we have good news for you.

1 CHAIR ROWLAND: Okay. I have Patty, then I have Trish, and then I'll take Norma and then
2 Donna.
3 COMMISSIONER GABOW: Thank you for coming. I have three questions.
4 You have an extraordinary array of information about innovation that you has come to you with all
5 these grants. Can you describe what you see as the three or four big bins in which those innovations lie?
6 That's the first question.
7 The second is, what metric or metrics do you see them primarily moving?
8 And the third is, certainly, you won't be able to fund all of the grants that you got, which seemed an
9 enormous number. Do you have any thoughts about how those innovations, which may be interesting but
10 weren't funded, can be broadly shared once the process of awards are over, because it is an extraordinary
11 number of applications they brought.
12 So those are my three questions.
13 MR. CAVANAUGH: Sure, and in that respect, on all three questions, were you were talking about
14 the Innovation Awards specifically?
15 COMMISSIONER GABOW: Yes.
16 MR. CAVANAUGH: Oh, okay.
17 COMMISSIONER GABOW: Sorry. I should have been clear.
18 MR. CAVANAUGH: That's all right. No, that's fine.
19 So, going in order, describe the three big bins. Unfortunately, it's more like 14 bins.
20 [Laughter.]
21 MR. CAVANAUGH: But, actually -- unfortunately for answering your question but fortunately
22 for us, I mean -- I'm trying to make sure I don't go beyond -- there's a focus -- I'll give you examples. I
23 don't think this will be comprehensive, but quite a few around readmissions. I mean, that's been a hot

1 topic and so there's a lot of interventions we got around specifically reducing readmissions.

2 Quite a few -- we were glad to see -- around integrating acute and behavioral health, and a lot of

3 different strategies for doing it, but that was sort of the theme.

4 A lot of IT-based, information technology-based, and by that, there were a lot of subsets, including

5 clinical decision making, telehealth, I'm trying to think of the others -- a lot -- some that replicated some of

6 what we were doing. So there were a lot of, just, primary care redesign, but using different ideas than what

7 had been in our models.

8 I'm trying to think. Ann, help me with the other bins in Innovation Awards that you can think of.

9 But I would say there weren't three or four. There were quite a few. And that's actually how we

10 approached it. We had to group them to make some sense of this, and then we tried to see, of these,

11 which seemed to have the most opportunity.

12 The metrics, and again --

13 CHAIR ROWLAND: Sean, are there many on long-term care specifically, or are they more acute

14 care oriented?

15 MR. CAVANAUGH: I would say significantly more acute care oriented, but not exclusively.

16 On your second question, what metrics, I would have to say that there was almost a mantra among

17 some that they're going to reduce hospital admissions, either preventable or readmissions, and reduce ED.

18 I mean, that was sort of a common theme.

19 But there were others, so I'll give you an example of how eclectic they were, and this is one that was

20 announced, the one in Emory University in Georgia. It's an interesting model where they're going to train

21 nurse practitioners from rural communities to staff critical care units at the rural hospitals but connected by

22 telehealth in Atlanta to intensivists. So what they were trying to reduce -- the metric they were trying to

23 reduce is these expensive transfers from rural hospitals to urban hospitals. That's not an example of a

1 typical metric, more of the eclectic ones. The readmissions, ED visits, and so forth are much more typical.

2 Sharing innovations, and I'm glad you asked the question about that, I should have mentioned that

3 an important part -- I mean, we have a lot of groups that do different work at the Innovation Center. The

4 two largest groups are our Evaluation Group and then our Learning and Diffusion Group, and currently,

5 the Learning and Diffusion Group is really working within the models, helping, for example, the Pioneer

6 ACOs, teaching them how to talk to each other and how to learn within that community. But that's

7 temporary. Eventually, their work will become outward-focused, which is, all right, the Pioneers are

8 learning from each other. Now how do other shared savings program ACOs learn from them? How do

9 people who aren't even ACOs yet learn from them? And that will be true not just for our models, but for

10 the Innovation Awards, too. So you'll see in the coming months and years quite a bit of that activity, and

11 we have a really great staff that will be working on that and they'll be very public about how they approach

12 it.

13 CHAIR ROWLAND: Trish.

14 COMMISSIONER RILEY: Well, I have a quick comment and then I want to follow up on Patty's

15 good questions. The comment is, as somebody who ran a CON program and had to deal with scope of

16 practice issues, I can't believe you actually said CON. I think States would be -- those are very political,

17 very difficult issues at a State level and I think States would welcome an ally and that's very encouraging.

18 I just wanted to follow up a bit on Patty's issue, because I think the notion of how these are

19 evaluated will be critically important. There's such a smattering of -- and that's what innovation is. It's

20 exciting. But it doesn't hang together. So I'm intrigued about what's the strategy to evaluate these?

21 How transparent will it be? How will we know what works? And I appreciate collegial learning and

22 learning collaboratives, but I think there needs to be the external eye for those who may be skeptical about

23 ACOs and whether they aren't just new monopolies. How will we really see how these many, many

1 innovations will be strategically reviewed and evaluated?

2 MR. CAVANAUGH: So we don't do anything without also accompanying a formal evaluation,

3 and that includes all the models I discussed, and it includes the Innovation Awards, too. And one of the

4 things we're trying to do in the Innovation Awards that speaks to Ms. Gabow's question, which is we need

5 -- there are going to be about 100 of these grants. We're not going to do 100 separate evaluations. We're

6 creating buckets of common interventions and things to see if we can group them. There will be multiple

7 evaluations, but not 100. So that's the first step.

8 So the second question, I think, is more interesting, which is the transparency of these evaluations.

9 I mean, I think CMS has a pretty good record of publishing in this, but I think we are trying to use the

10 evaluations for two purposes. One is for real-time process improvement, so they're serving that purpose,

11 which is constant feedback to the providers and the States or whoever is participating in it so that they can

12 make ongoing improvements to what they're doing. But then the officials stand back and report, how is

13 this going.

14 I know we've always talked about being transparent and public about that, but I don't know that

15 we've been specific about how that would happen and I'd be happy to talk to you further about that. I

16 think it's an intriguing concept, which is, I mean, hold both the Innovation Center and the providers who

17 are taking our money and engaging in these to some public accountability, I think, is an excellent idea.

18 CHAIR ROWLAND: Norma.

19 COMMISSIONER ROGERS: Hi. Thank you for coming. I just wanted to ask you a question,

20 because I noticed that on primary care transformation, on the slide presentation, you had graduate nurse

21 education, GNE demonstration. But when you go back to your tables, you don't have it listed. Is that

22 GNE money coming from HRSA or is it coming from you all?

23 MR. CAVANAUGH: It's coming from a specific appropriation in the Affordable Care Act, and

1 the reason it's not in -- I think I see what document you have -- it was announced subsequent to that
2 document.
3 COMMISSIONER ROGERS: I see. Thank you.
4 MR. CAVANAUGH: You're welcome.
5 CHAIR ROWLAND: Okay. Donna.
6 COMMISSIONER CHECKETT: Well, thank you for coming. The scope of the
7 demonstrations is broad and intriguing. I think one of the ones that is probably a sleeper for most people
8 but really catches my attention is the Medicare Emergency Psychiatric Demonstration, and the reason is
9 because so much of our current Medicare policy is arbitrary. And, in fact, the Institute for Mental Disease
10 exclusion or prohibition is among, you know, high on the list of arbitrary public policies.
11 So my question to you is what exactly are these demonstrations out to prove? Are we looking to
12 see if care can be provided more cost effectively? And I don't know if you've got that information, and I
13 just want to really put the question in the context of our March report in which we talked about the fact that
14 the single population that is most expensive to a State Medicaid program is actually not the dual eligible. It
15 is the Medicaid-only individual with disabilities, 50 percent of whom have a behavioral health diagnosis.
16 Yet under the IMD prohibition, a State cannot get Medicaid match for those adults who are in an institute
17 for mental disease.
18 So it's a long story. I did want to provide some context to the question because I'm hopeful that
19 you're going to tell me that we're going to be moving forward and addressing this really anachronistic public
20 policy position.
21 MR. CAVANAUGH: So I --
22 COMMISSIONER CHECKETT: So the answer should be, yes. It's a total set-up, and the
23 answer is --

1 [Laughter.]

2 MR. CAVANAUGH: I can send you more information --

3 [Laughter.]

4 MR. CAVANAUGH: So that was one of the mandated demos, so it's not under our typical
5 authority. So were it proven successful, we can't simply expand it, but we can take lessons from it and do
6 other things.

7 COMMISSIONER CHECKETT: Okay.

8 MR. CAVANAUGH: I can send you some of the metrics we're using in the evaluation of what
9 we're specifically trying to achieve. It's not one that I'm very well versed in.

10 But, again, it does speak to -- when you start working with Medicaid and the States, there's lots of --
11 I'm preaching to the people who taught me this -- there's lots of sub-populations where there's a lot of
12 opportunity and a different set of rules and obstacles, but also opportunities. So this would be one of a
13 whole litany of things, I think, we're exploring in the context of trying to find -- again, our statutory mandate
14 is to reduce costs, so it would have to be in the context of a model that could ultimately reduce cost. I
15 don't know that this specific demo is structured necessarily to reduce costs, but it could produce lessons that
16 could be put into another model where we could do that.

17 COMMISSIONER CHECKETT: Great. Okay. Thank you.

18 CHAIR ROWLAND: Sara.

19 COMMISSIONER ROSENBAUM: I wanted to follow up on Donna's question because it
20 actually raises sort of another dimension of the authority of the Center. The most interesting thing that the
21 Center can do, as far as I'm concerned -- of course, I'm a lawyer, so I tend to be more interested in these
22 things -- is not so much to fund demonstrations. They're fascinating, but it's the translation into changes
23 in underlying Medicare and Medicaid policy that is really the powerhouse here. You know, which of these

1 things yields the kind of results that would change actual ongoing permanent policy?

2 So, of course, Denise's example is a perfect example of where you might affect a COP with the

3 results of a perinatal project, and Donna's example is one where, you know, CMS might think about, which

4 it could do, considerably narrowing by regulation the IMD exclusion, the scope of the exclusion, which has

5 grown monstrously over almost 50 years. I mean, when it began, it began as something to stop States

6 from funding public mental institutions under Medicaid for all kinds of really wonderful reasons at that

7 point. And now, what it tends to do is deter the growth of much more community-based living

8 arrangements for people with dual diagnoses because you get labeled as an IMD.

9 And so I guess my question is what is the evidentiary standard that CMI is going to set for itself? I

10 mean, seriously, I understand the cost is an issue, but within the broader CMS, what level of evidence and

11 over what period of time do you apply to know that you've got something that's showing some

12 improvement in terms of short-term quality, long-term cost impact. I think, once you get beyond the next

13 ten days, it's also speculative. who knows what things are going to cost. So I assume that there's been a

14 tremendous amount of discussion inside the agency about what we as an agency need before we can go

15 change the COPs or change the IMD exclusion, and I can't think of any sort of overarching document that

16 I've read that kind of puts the agency's regulatory framework in perspective. It's all around the individual

17 innovation. So I wonder if you can talk a little bit about that.

18 MR. CAVANAUGH: Sure. Thank you. So the statute is very specific about not the evidentiary

19 standard, but the process by which we can expand and take a model national. But as you point out, that's

20 not the only way to influence change, but let me just talk about that briefly.

21 What we're supposed to do is test models, and then when the Office of the Actuary certifies that it

22 has reduced cost, then the Secretary through rulemaking can expand the scope of it and take it national.

23 But I think, if I understand what our lawyers have told us, the distinction there is it's still a model that's

1 being tested, isn't it? It can be national and can be big in effect and improve care and save a lot of money,
2 but it's still a model that's being tested.
3 What is less clear is, clearly, if we have evidence, the rest of CMS has all these levers, as you said,
4 Conditions of Participation, IMDs, all the rules and regulations that apply throughout the program. What
5 the standard is for them to say, well, we've learned from that and we're not pursuing the Office of the
6 Actuary path because we're just so -- let me give you an example.
7 The Pioneer ACO model has many features that are different than the Shared Savings model, but
8 clearly, the purpose was to test things that could then be brought into the Shared Savings model. So what
9 is the evidentiary standard for when they look at ours and say, oh, we really like what you did there and next
10 year's rule will reflect that? And I have to be honest that I'm not sure what that standard is yet there. As
11 you indicated, there's been quite a bit of thought about it, but it also seems a bit premature because these are
12 all just getting out of the gate.
13 But I just wanted to make clear, there are these two paths, the one specified in statute and the less
14 formal one which I think you identified, but it's very real that the Administrator can decide to pursue it.
15 COMMISSIONER ROSENBAUM: So just to follow up, then. So you could decide -- you,
16 whether you would or somebody would -- CMS could decide, let's say, three years from now, if it thinks it's
17 got a model of care for people with dual diagnoses, to, on its own initiative, put out a Notice of Proposed
18 Rulemaking that redefines IMDs to carve a new exception out, to say, we will not classify an entity as an
19 IMD for State option purposes if it has the following attributes because this is what we learned from our
20 demonstration.
21 So it's not just that you will fund demonstrations into perpetuity. At some point, the question is,
22 can you -- as I read the statute, you actually are empowered to cross over into ongoing policy even though
23 the policy evolution would grow out of your demonstrations. You wouldn't be permanently authorizing a

1 demonstration. You would be able to make permanent changes in underlying regulatory definitions,

2 regulatory limitations, that inhibit the translation of promising approaches into mainstream financing, I

3 assume.

4 MR. CAVANAUGH: So I believe the answer is yes, and with all sorts of conditions, which is

5 assuming that change was within the statutory authority that CMS already had. So presuming it had some

6 statutory authority to do what it did and that it still has the statutory authority to undo it, it can rely on

7 evidence from a model that we've tested.

8 CHAIR ROWLAND: Andy.

9 COMMISSIONER COHEN: Hi, Sean. Thanks for being here.

10 Correct me if I am wrong, but I think I understand that your underlying statutory authority gives

11 you a different -- so that there's some asymmetry in the authority that you have to waive Medicare

12 provisions and waive Medicaid provisions in the demos. So can you talk a little bit about that, since we

13 have the luxury of being able to think about recommendations for legislative change, and maybe talk about

14 some examples where that may have been a barrier to some otherwise viable concept, if there is one, or, you

15 know, that if you had had the authority to do it, there may be some nuggets of some project that you'd like

16 to do.

17 MR. CAVANAUGH: So thank you for the question. So the statute says we can -- we can't do

18 this willy-nilly. I forget the exact language, but when necessary to test a model, we have the authority to

19 waive, I think, essentially all the provisions in Title 18 related to Medicare and Title 11 related to fraud and

20 abuse and other things.

21 In Medicaid, it is constrained, as you said, to three provisions. We have the authority to waive the

22 State wideness rule, the actuarial soundness rule around managed care rates, and then -- this one I know the

23 least -- there is a statutory requirement that when States engage in provider rate setting, that they use some

1 sort of public process, and we have the authority to waive that.

2 Having said that, those are authorities specific to the Innovation Center. They don't in any way

3 impinge upon CMS's authority under 1115, 1950. So all the existing waiver authorities that have always

4 resided within CMS are there.

5 I don't want to identify any places where we have been constrained because I don't know that that's

6 happened yet. But I would just say that were we to need a broader authority to do something, we might --

7 and I would have to check with our General Counsel -- we might do it in conjunction with our colleagues at

8 CMS in the context of an 1115 waiver.

9 CHAIR ROWLAND: Sean, you said that you have gotten around the budget neutrality issue, but I

10 assume the budget neutrality issue still stays for the Medicaid 1115 waivers, or not? Do you know?

11 MR. CAVANAUGH: So I don't know that we've particularly posed that -- I'm sorry, have posed

12 that particular question to the lawyers, but yes, the statute says, in testing models, we are not subject to

13 budget neutrality. As you know, 1115 waivers historically have --

14 CHAIR ROWLAND: Except I don't think that was in statute. I think that was also an

15 administrative decision.

16 MR. CAVANAUGH: Yes. So I apologize. I can't directly answer your question.

17 CHAIR ROWLAND: But my question was, you mentioned evaluations, and obviously one of the

18 areas that we will be looking at are the integration models for the dual-eligible population, and it's my

19 understanding that -- have you contracted for an evaluation of those models or what are the plans to

20 evaluate those major demos?

21 MR. CAVANAUGH: We are somewhere -- yes. So, first of all, it will be our evaluation team

22 that will issue the -- in cooperation with Melanie Bella's staff. And, I forget, we are issuing a statement of

23 work and accepting bids. I don't remember where we are in the process, but that is underway.

1 CHAIR ROWLAND: But there will be a formal evaluation to go with the demos --

2 MR. CAVANAUGH: Absolutely.

3 CHAIR ROWLAND: -- a State --

4 MR. CAVANAUGH: Yes. So again, anything that is done with our authority, we are evaluating.

5 CHAIR ROWLAND: Okay. Other questions for Sean? Norma.

6 COMMISSIONER ROGERS: One last question. So are the States doing their own evaluation

7 of the demos that they have also?

8 MR. CAVANAUGH: Under the duals financial integration?

9 COMMISSIONER ROGERS: Mm-hmm.

10 MR. CAVANAUGH: I don't know the answer to that.

11 COMMISSIONER ROGERS: Okay.

12 MR. CAVANAUGH: But I could get you the answer.

13 CHAIR ROWLAND: Any other questions?

14 If not, thank you. I think we're interested in staying in touch with you on how these demos are

15 proceeding and also would welcome your thoughts as we go along on sort of where the evaluations of some

16 of these major demos are, because one of the things we want to know is what information will we have to

17 continue our work.

18 MR. CAVANAUGH: Sure.

19 CHAIR ROWLAND: But thank you very much for joining us.

20 MR. CAVANAUGH: Thank you for having me.

21 CHAIR ROWLAND: And in the spirit of really trying to look at Medicaid's role as a participant in

22 the health care system, and as a prudent purchaser, I want to bring Ellen back up to brief us on where our

23 work is going with regard to looking at how to be a better conduit for Medicaid value-based purchasing.

1 ### **MEDICAID IN THE CONTEXT OF THE HEALTH CARE SYSTEM: ACCESS,**
2 **QUALITY AND VALUE**
3
4 DR. O'BRIEN: Thanks, Diane.
5 The presentation I'm working from is included in your binder at Tab B -- I'm sorry, Tab 2 for this
6 public session.
7 CHAIR ROWLAND: And this, for the Commission, is what we would like to have, in part, as a
8 setup to our discussion of access and part of our June report.
9 DR. O'BRIEN: So in the session I want to provide an overview of this introductory section for
10 the June report. The section is intended to provide a context for Sections A and B of the June report,
11 which you also have drafts of in your binder. Section A provides information on data for measuring access
12 in Medicaid. And Section B provides a review of access to care for non-elderly adults in Medicaid, and
13 you'll hear more about those chapters this afternoon.
14 So, in addition to as it provides a context, this introduction describes Medicaid's role as a purchaser,
15 all of this fairly briefly, and highlights the importance of access measures as a tool for monitoring and
16 improving Medicaid's performance.
17 And in this session, as always, we'd like to solicit your comments and feedback on the chapter.
18 The introduction describes Medicaid's role as a purchaser and briefly describes the goals of
19 Medicaid's purchasing strategies, highlights recent innovations, and describes how purchasers -- Medicaid
20 and others, in general -- evaluate and improve their performance.
21 Medicaid is a purchaser, as you well know. Medicaid is among the nation's largest purchasers of
22 health care services and long-term services and support, spending $432 billion in fiscal 2011 to purchase
23 health and long-term services and supports for nearly 70 million beneficiaries. Always accountable for the

1 efficient use of the public resources and, in the current environment, facing significant resource constraints.
2 Medicaid program administrators continually seek performance improvements or better value for
3 expenditures where value means better access to care, better care in services, and better outcomes of care at
4 the same, or ideally, lower cost.
5 Delivering access to care is a basic requirement for any health care delivery approach, and therefore
6 this chapter seeks to put our discussion of access into a broader context and preview our broader agenda for
7 evaluating Medicaid's impact -- for evaluating the impact of Medicaid's purchasing strategies.
8 What are those Medicaid purchasing strategies? Today, purchasing strategies as designed by
9 Medicaid and other public and private purchasers are undergoing an evolution. A variety of service
10 delivery and payment innovations are being developed to promote the goals of high quality and
11 cost-effective care, including a focus on cost-effective primary care and chronic disease management, better
12 integration and coordination of care across primary, acute, behavioral health and long-term services and
13 supports.
14 Along with these delivery system innovations, payment policies are increasingly designed to increase
15 accountability for desired outcomes and purchasers seek to leverage these opportunities by aligning with
16 other payers, some of which I think Sean Cavanaugh of the Innovation Center at CMS mentioned in his
17 discussion this morning.
18 Medicaid has often been at the forefront of these developments, which include patient-centered
19 medical homes, primary care case management, fully integrated managed care models, bundled payments for
20 episodes of care, and global payments for accountable care organizations.
21 A key aspect of this endeavor, of these purchasing strategies, is clearly to measure and monitor
22 systems to evaluate their performance with respect to key measures, including access to care, quality of care,
23 outcomes of care, and cost.

1 Just picking up on that idea of measuring, purchasers must evaluate and continually seek to improve
2 upon the ability of delivery and payment models to achieve these goals. And since a key goal of any
3 purchasing strategy is to ensure that enrollees have appropriate access to services, a goal of any monitoring
4 improvement strategy is determining whether appropriate access is being achieved and, where and if it is
5 not, developing strategies to address any gaps that may be widespread or that may affect particular services
6 or particular subpopulations. So purchasers have to determine whether access is a problem, how much of
7 a problem, for which populations, in what geographic areas, for what services and what delivery systems and
8 under what payment approaches.
9 Complete and timely assessment of enrollees access to appropriate care across types of services,
10 models and populations are needed to assess the impact of service and payment innovations and ultimately
11 judge the success of Medicaid's purchasing strategies.
12 The introduction, however, also makes the case that any meaningful effort to assess access in today's
13 environment needs to take into account concerns about cost and value. It is possible -- we are not talking
14 about access to any service at any time, but it's possible for a purchasing strategy to assure access to care but
15 at costs that are too high or with outcomes that are too low. So to evaluate whether purchasers are
16 improving value and getting better outcomes per dollar spent or better value, we have to also measure
17 outcomes and costs.
18 But we don't have very good measures of the outcomes of care across populations over time, and
19 we'll need to develop better measures that address outcomes for Medicaid's diverse populations.
20 The chapter closes with a section called Looking Forward that discusses the key questions that
21 program administrators and other stakeholders would ask about Medicaid's purchasing strategies. A few
22 are listed here: Which cost containment strategies are least likely to disrupt access or may improve access?
23 Can new payment and service delivery models lower costs while assuring access to service and treatments

1 that benefit patients? And can new arrangements improve coordination and quality and generate savings?

2 The chapter closes by noting that these questions can guide MACPAC's future analysis.

3 With that, I guess I'd like to take your comments.

4 CHAIR ROWLAND: Trish.

5 COMMISSIONER RILEY: Thank you.

6 I liked the narrative a lot because it talked more about the appropriate use of access and the broader

7 complexity of this issue. And I think it could be reflected a little bit more strongly in the key questions.

8 So that we might want to ask some kind of question about which purchasing strategies assure the

9 appropriate delivery of effective and efficient care. Because I think it just doesn't reflect the narrative in

10 the questions and I think that's key to the complexity of this issue.

11 CHAIR ROWLAND: David.

12 VICE CHAIR SUNDWALL: Thank you.

13 This is -- we're making progress. I like what you've discussed.

14 I would appreciate if we might be able to weave in something related -- instead of just talking about

15 performance measures but public health measures. We just completed a report, the IOM and I was on the

16 Committee, integrating public health and primary care. And it really did cite some terrific examples of

17 where they've achieved better public health outcomes by focusing on primary care management.

18 I think that while we're all looking for savings and reducing hospital readmissions, we don't often

19 enough talk about the public health status or the commonly used health indicators of the population. So if

20 we could -- I don't know -- somehow weave in here that we are looking at what's already out there in public

21 health measures of populations, I'd appreciate that.

22 CHAIR ROWLAND: I also think that one of the things we've talked about is changing the

23 incentives in the health care system and changing the incentives for the providers and the patients. And

that as part of value-based purchasing, we really need to look at what the current incentives are and how to perhaps change those in a better direction. So I would urge that we kind of add that in to our framework, as well.

Sara.

COMMISSIONER ROSENBAUM: This looks like a great chapter and I think will be a real contribution.

I'm going to ask the Burt Edelstein memorial question, because Burt's too shy to ask his own question.

CHAIR ROWLAND: Oh, really?

COMMISSIONER ROSENBAUM: Yes, we know how shy Burt is.

What do we do about those issues where Medicaid is not engaged in what we might characterize as too much or wasteful or inappropriate spending, but where it's not spending anything and it should? And of course, there's no better example of this than adult dental care, which has just been obliterated from so Medicaid programs at this point.

Every time you read something about dental and oral health, you realize the phenomenal waste of resources that comes from having such a poor oral health system for lower income people. And I'm wondering if this -- if we can deal, in this chapter, with the investments that Medicaid is not making as a purchaser, it's not just that it's not spending enough or its prices are low. Usually we are dealing with Medicaid and its prices are low and it should pay a higher price because it doesn't attract enough of a network.

But this is a case where it's just absolutely a payment exclusion. And if we thought about it, there are other examples in Medicaid where there are very important payment exclusions around services that are undeniably health care. I mean, it's not one of these services where people say well, that's social or that's

1 educational, or whatever. But there may be other services that would be really important investments that

2 are the first places to get cut.

3 And you just cannot be a smart purchaser if you do not make it possible for people to deal with oral

4 health problems. Or vision care. There are certain kinds of vision care that are very hard for adults often

5 to get.

6 And this has been the great achievement of EPSDT for children, that you can't make these kinds of

7 cuts but they are not appropriate cuts for adults.

8 DR. O'BRIEN: I agree, but the presentation as it is now is fairly abstract and doesn't talk about

9 what these higher value services are. We can certainly try to mention some, you know more timely access

10 to, lower cost alternatives. Dental care could clearly be one, and then there would be this issue of how we

11 -- whether we confront those very difficult issues about, the redistribution, potential redistribution of

12 resources that's involved in making that happen.

13 CHAIR ROWLAND: Burt, do you have a comment?

14 COMMISSIONER EDELSTEIN: I've been well represented, by counsel.

15 [Laughter.]

16 CHAIR ROWLAND: Andy.

17 COMMISSIONER COHEN: I know this isn't the focus of this introduction, but when I think

18 about Medicaid as a purchaser, I just feel like we have a lot of discussion of these payment models,

19 monitoring outcomes and monitoring other things. But I feel like we're missing a little piece around

20 management of the program. I mean, to be a good purchaser, you not only have to have the right policies,

21 but you have to implement them the right way, you have to pay for them the right way. It's not just a

22 model of payment, it's actually also sometimes the level.

23 So I'm just wondering, again, maybe it's really a placeholder for future work, but if there might not

1 be something in there around just the way -- the program has to be structured to make it an effective

2 monitor, you know, an effective purchaser. And I think that's a place where a lot of states are not. And

3 I'm not sure that there's a lot of policies or work around trying to orient programs more in that direction.

4 DR. O'BRIEN: I think this chapter hints at the issue of to be an effective purchaser you have to

5 have an infrastructure in place, and the infrastructure is data collection and the ability to craft indicators and

6 to monitor. But there are probably a broader set of issues we could bring in.

7 CHAIR ROWLAND: Well, we need to also bring in administrative capacity, the staffing, which

8 we know is also an issue in many of the states increasingly.

9 Other comments? Denise?

10 COMMISSIONER HENNING: I just kind of want to mention that one of the things we have to

11 be careful of is that when we're looking at outcomes, that we're actually measuring the correct things

12 because there's been a lot of changes, especially in women's health, where now with some of the newer pap

13 smears that are out there you don't have to do them every year.

14 So if you look at that population and you say okay, we're going to look and see how many people

15 have had a pap smear in the last year and we're going to ding you if they haven't, if only 10 percent of your

16 population or whatever, 20 or 30, have had pap smears in the last year, well that might have been

17 appropriate.

18 So we need to watch the moving targets that are out there when it comes to health care.

19 And I noticed in one of our reports they looked at mammograms for women that are 30 and over.

20 Well, they're not even indicated unless they're at least 40. And it depends on who you believe whether it's

21 40 or 50. But most OB/GYNs go with the 40, unless there is a family history or some suspicion of a

22 reason why you should do one earlier.

23 So I think we just need to be careful that we're measuring the right things and that we're reporting

1 on the right things when we're looking at access and whether people are getting the correct care.

2 CHAIR ROWLAND: Burt. Sara left, so you have to talk.

3 COMMISSIONER EDELSTEIN: I'd like to suggest that we take a look at the consequence of

4 the problem that Sara raised.

5 If you take a look under Tab 7 under MACStats, Table 5b, the measure used in National Health

6 Interview Survey for oral health status is a drastic one. It's equivalent to amputation. It is the loss of all

7 natural teeth. So complete edentulousness, hardly the outcome that we want for people on public

8 programs.

9 For those over 65, those who are Medicaid-eligible and who have not had the benefit of a dental

10 benefit through their Medicaid, 43 percent are completely without teeth compared with only half that

11 number who have enjoyed any kind of private coverage.

12 So the only thing I wanted to add to what Sara said is that by the exclusion of oral health services

13 from Medicaid, the consequences are dire. If you take a look at the next younger age group you see those

14 who are essentially in the program because of disability also have very high levels of edentulousness, even

15 though they are not yet seniors in age.

16 So the program, by failing to provide the essential preventive and basic repairative services ends up

17 by default with these essentially uninsured Medicaid beneficiaries losing their entire dentitions.

18 CHAIR ROWLAND: Okay. Other comments?

19 Is this chapter the direction, however, that you see us starting to frame the issue? Donna?

20 COMMISSIONER CHECKETT: I am comfortable with the direction of the chapter. I know

21 we've discussed before just the importance of our being sensitive to the fact that there can be programs,

22 services, providers that are access problems for the entire population. And I just want to emphasize that.

23 Just as Medicaid has many challenges, it also has problems for which it is not the solution.

1 And so I think it's just important that we be very sensitive to that. I think we've discussed it. I
2 want to re-emphasize that. It's the only concern I have with the access issue in chapter.
3 Thank you.
4 CHAIR ROWLAND: Well, maybe that warrants an addition that recognizes that if you're a
5 purchaser in an area where there are real shortages, as we'll get into in our afternoon discussion, that your
6 options may not be the ideal set of options to be a prudent purchaser.
7 Other comments?
8 Are you ready to go to the table and write it up, Ellen?
9 DR. O'BRIEN: No problem.
10 CHAIR ROWLAND: I think the other thing that might be reflected here is, again, the diversity
11 which we keep hitting of the population and the purchasing strategies for one part of Medicaid's population
12 may have to be very different from another, which raises -- to Andy's point -- program management has a
13 lot of different challenges because they're not purchasing one set of services on behalf of a pretty
14 homogeneous population.
15 And I think that's a point that we need to keep making, especially maybe even pulling back some
16 examples of our disability discussion of the fact that the disability population has one title but has so much
17 diversity within it, that we emphasize that just as a setup to this chapter.
18 Okay. With that, I think we're a little ahead of schedule but why don't we adjourn and take our
19 lunch break. Why don't we plan to reconvene at 12:30 instead of one o'clock.
20 Thank you, we will stand adjourned until 12:30.
21 [Whereupon, at 11:48 a.m., the meeting was recessed, to reconvene at 12:30 p.m., this same day.]
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1 AFTERNOON SESSION [12:58 P.M.]

2 CHAIR ROWLAND: Okay. Welcome back to our MACPAC discussion. What we are going
3 to focus on in this session is to continue to discuss Medicare and Medicaid dual enrollees and the state
4 proposals that are going to CMS and moving forward for dual-eligible demonstrations that look at the
5 integration of Medicare and Medicaid services and to look at the impact of some of these potential
6 demonstrations on both the coordination of care for the Medicaid and Medicare population and also for the
7 potential savings, if possible, from the better integration and service delivery.

8 So I'm going to ask Ellen to walk us through some of the key issues and to take your discussion as
9 we go through each of the issues.

10 **### UPDATE ON MEDICARE-MEDICAID ENROLLEES**

11 DR. O'BRIEN: Excellent. I think we're at Tab 3 in your binder.

12 As Diane mentioned, in today's presentation we'll review the goals of the CMS financial alignment
13 demonstration; remind you of the key steps and timeline focusing on the capitated model demonstration
14 that I'll describe; provide a very brief update on the state proposals, where states are at; and then focus the
15 presentation on key design features of the capitated models; and then raise some key considerations that
16 could be used to evaluate the design and implementation of the demonstrations.

17 In terms of the goals of the financial alignment demonstration -- this is straight from CMS -- the
18 goal is to provide a more seamless experience for beneficiaries by focusing on patient-centered models that
19 promote coordination; developing a more easily navigable and simplified system of services for
20 beneficiaries; ensuring access to needed services; establishing accountability for outcomes; and evaluating
21 data on access, outcomes of care, and beneficiary experience to ensure beneficiaries receive higher-quality,
22 more cost-effective, better care.

23 The demonstration is based on evidence that there are opportunities for improvement in the case of

1 dual-eligible beneficiaries. We know that dual eligibles have diverse needs and often complex needs that
2 may not be well met in the current environment, that they face access challenges today, that they often have
3 complex care and face fragmentation of service delivery, and that fragmentation can lead to lack of
4 coordination with all kinds of results. Unmet needs for care and duplication of services is another
5 potential outcome, and that leads to concerns about costs and the potential to use lower-cost alternatives to
6 improve care and outcomes.
7 We propose that there are two questions, then, about whether the demonstrations will adequately
8 address these issues, the problems that duals face in the current environment, and then a question about
9 whether the problems have, in fact, been correctly identified: fragmentation, lack of integration,
10 conflicting incentives between Medicare and Medicaid, and problems with access, for example.
11 CHAIR ROWLAND: Ellen, are there studies that can be cited to show this fragmentation?
12 DR. O'BRIEN: There are some studies. We haven't made as much progress as we would have
13 liked on documenting that, but that's certainly on our agenda. We have been reviewing the studies that talk
14 about the characteristics of the population, that show that duals have more limited access to care, that show
15 that duals as compared to the rest of the Medicare population often experience lower clinical quality of care.
16 The evidence, I think, on the impact of fragmentation, lack of coordination, needs to be -- we need to look
17 at that. And so we'll be compiling that, and then evidence not only on what the challenges are but
18 evidence on what works, what do we know about how care coordination has worked in Medicare, about
19 how it has worked in Medicaid waiver programs and in other kinds of settings to say -- to bring those
20 lessons to bear for the design of the demonstration and to think about then how we evaluate the
21 demonstration as it moves forward.
22 CHAIR ROWLAND: Great. Thank you.
23 DR. O'BRIEN: And, again, just to remind you, CMS has proposed two approaches to financing of

1 the demonstration, and states have adopted in their proposals one or both of these models. The first is a
2 capitated model under which managed care plans will provide the full range of Medicare and Medicaid
3 services under a prospective capitation. This model builds savings to CMS and the state due to this
4 integrated managed care into the rate. The second is a managed fee-for-service model under which a state
5 arranges care management services for dual eligibles that coordinate the full range of services -- again, the
6 full range of Medicare and Medicaid services, building perhaps on their primary care case management
7 experience or patient-centered medical homes.
8 States are then eligible to benefit from savings, to share in the savings that may accrue to Medicare,
9 for example, so long as they meet certain performance standards.
10 COMMISSIONER GABOW: Do you have any insight into why which states picked which
11 model? Does it have to do with the delivery model they have, the payer types they have?
12 DR. O'BRIEN: I think we do see that some states have established successful primary care case
13 management programs and are looking to build on those. Others have Medicaid managed care capacity
14 that they're looking to extend. So I think the current environment has a lot to do with what they choose,
15 and then perhaps there are expectations about which models will create the best set of incentives to really
16 improve the care for duals. So there seem to be a number of states that those the capitated model. They
17 must believe that addressing those conflicting financial incentives by integrating the stream of financing is
18 really going to have a major impact on the quality of care duals receive.
19 COMMISSIONER GABOW: And in the states that picked a model that they already had, do they
20 have evidence that that model had efficacy in either quality or cost?
21 DR. O'BRIEN: We're certainly going to be looking for as many evaluations as we can find of
22 those existing state programs and what they're learning from them. But I believe that states will implement
23 these programs and they learn by doing and they see quality improvements over time, and so they're looking

1 to build on that experience and achieve better outcomes for the population.

2 CHAIR ROWLAND: I think the State of New York is using both models, but it's starting first

3 with case management of the fee-for-service for a defined part of its disability population.

4 COMMISSIONER COHEN: I think it's the population that does not need long-term services and

5 supports.

6 CHAIR ROWLAND: And then later goes to a capitation model in 2014 which may be a strategy

7 also, just what they can do quickly versus what they can do down the road.

8 COMMISSIONER CHAMBERS: Could I just add a comment about California's going to do

9 both models starting with the capitated because that's the delivery model that serves many of the Medicaid

10 beneficiaries, but they really want to expand it into more rural and frontier counties, and they really intend to

11 focus the managed fee-for-service in those counties since there's not much -- there's no existing managed

12 care there now.

13 COMMISSIONER CHECKETT: Patty, I think that's a great question, and I took a quick look at

14 it, and it really is consistent where the states that don't have capitated managed care now for either their

15 disabled population or at all are the ones that are doing managed fee-for-service. So it seems very

16 consistent with the models that are working out for those states and their unique populations.

17 COMMISSIONER RILEY: It strikes me here and in our design discussion that one of the --

18 simplistic as it is, one of the biggest challenges to coordinating care for this population is to have one plan

19 of care and to have one plan of care that's funded. And it strikes me that in many models that we've

20 experienced to date, that doesn't happen. There are multiple case managers or different sub-services. So

21 what we need is one plan of care with one case manager where you can allocate resources based on the plan

22 of care. And it's one plan of care, be it designed by a team or not, but somebody is in charge of that one

23 plan of care under which everything else fits.

1 So it strikes me that there's a natural capacity here to sort of measure how effectively that's done in
2 two very different models. But throughout it, we sort of assume capitation takes care of all that, and I'm
3 not sure that's correct. So when we get -- I won't mention it again, but when we get to the discussion of
4 the design, it seems to me how a plan of care is developed, who can authorize the expenditure of dollars,
5 and how that works is critical to the success of these models because over time, of course, the care manager
6 for Medicaid couldn't authorize spending for Medicare benefits. And unless that happens, then you've
7 really not achieve what the promise of these dual-eligible demonstrations really is, it seems to me.
8 COMMISSIONER ROSENBAUM: Sort of along these same lines, there are so many different
9 initiatives going by different monikers now in, you know, sort of turn on the engine, rev them up, and
10 they're all going, I can never remember all of their names. But certainly when the accountable care
11 organization model was being brought up, a fair amount of thinking, as evidenced by the rule, went into the
12 management of particularly high-cost enrollees, including duals. In fact, there's a fair amount of language
13 about nondiscrimination against more underserved and lower-income populations in the formation of
14 ACOs.
15 And so I can't help but wonder sort of along the issues, the lines of what's been raised, and this sort
16 of goes generally to how CMS is approaching such a deluge of desired initiatives, whether an effort is being
17 made in the managed fee-for-service states, for example, or even in the capitation states to introduce large,
18 integrated groups as part of it, whether it's managed fee-for-service or whether it's capitation. In other
19 words, we're still talking only about the financing end of things, so the question is: Underneath the
20 financing, what is CMS' thinking about, going to your point, Trish, what the service delivery model is that
21 would be that we end up with, you can pay for it, case method, a capitation method, an encounter method, I
22 mean, you can go on and on. But the question is whether it's still sort of skittering across the top of the
23 financing or getting down into this question of how is care organized for people and has the ACO initiative

1 and CMS had -- you know, caused CMS' duals office to think about what it wants out of service delivery.

2 COMMISSIONER CHAMBERS: And I think states have given a fair amount of consideration to

3 that, and it just may be that our materials don't give enough attention to that, having focused on the

4 financing end of things, and we can bring that out in future work.

5 CHAIR ROWLAND: Okay. The timeline.

6 DR. O'BRIEN: As I said, this presentation focuses on the timeline and the issues and the design

7 and implementation of the capitated models, looking at the key steps and the timelines dates have been

8 since last fall: planning, developing, designing these demonstrations, then posting on state websites the

9 demonstration proposals and receiving public comment over the spring now and into the summer. They

10 are then submitting those proposals to CMS for an additional 30-day comment period. A number of states

11 are actually through that comment period. A number are in it right now.

12 The next step then would be once CMS determines the proposal has met standards and conditions,

13 CMS would work with the states to develop a state-specific memorandum of understanding based on

14 templates that were provided in the July 2011 state Medicaid director letter. CMS had set a target date of

15 July 30th for completion of plan selection for the capitated model demonstration, and a deadline of

16 September 2012 for signing three-way contracts between the state, CMS, and the plan.

17 Then in October of 2012, the Medicare open enrollment period begins, and in January 2013, states

18 that are proposing to implement in 2013, this new coverage will begin for beneficiaries, and the

19 demonstration would last three years.

20 In terms of a quick update, 26 states have posted draft proposals for public comment, 20 states

21 proposing to use the capitated model, nine states the managed fee-for-service model, and three states both;

22 or if you don't want to do the subtraction, 17 proposing a capitated model only, six proposing a managed

23 fee-for-service model only, and three states proposing both to get to 26. And ten states have submitted

1 proposals to CMS, seven states have submitted a capitated model proposal with a 2013 proposed start date,
2 including Illinois, Massachusetts, Michigan, Minnesota, Ohio, Washington, and Wisconsin. And you see a
3 couple of states have submitted with a 2014 start date and a couple of states with a 2013 start date for a
4 managed fee-for-service model.
5 COMMISSIONER CHECKETT: Ellen, do you know on the start dates for 2013, are those
6 January start dates, or are they throughout the year? I know generally with Medicare Advantage you start
7 at the beginning of the calendar year.
8 DR. O'BRIEN: That's correct. And I believe there are CMS materials that indicate that they
9 envision this starting in January 2013 and are willing to consider somewhat later start dates, April, you know,
10 rolling starts.
11 CHAIR ROWLAND: I think Michigan was asking for a mid-year start, which Melanie thought
12 was problematic because of the need to coordinate it with the Medicare open enrollment period.
13 Ellen, do you know -- some of these proposals, as we look at them, are not for all the dual
14 population. Some of them are more targeted like Wisconsin, I believe.
15 DR. O'BRIEN: That's correct. I'll talk about that a little bit, but for the most part the states are
16 proposing to enroll most or all of their full benefit duals, but there are some key exclusions that I will
17 mention briefly when we get to target population, which is now, because target population is the first design
18 element we wanted to draw out, and then this presentation focuses on these nine elements of the design of
19 the capitated model demonstrations.
20 Moving straightaway to target population, all or most full-benefit duals would be enrolled across 26
21 states. There are 4.8 million full-benefit duals, but with these exclusions that are mentioned below, the
22 target population would be 3.3 million. Looking just at the seven states proposing a 2013 implementation
23 of a capitated model, the target population is 1.1 to 1.4 million, depending on how you count California.

1 So 1.4 million duals potentially eligible to be enrolled in the financial alignment demonstration starting in
2 2013 in those seven states.
3 This target population, as we know, has a wide range of health care needs and health conditions and
4 cognitive and physical challenges. They use a wide array of services and include people in nursing homes
5 and home and community-based settings where they receive long-term services and supports. It includes
6 people with serious mental illness, others with complex high-cost medical conditions, others who may be in
7 relatively good health but are low-income Medicare beneficiaries.
8 States are excluding some sub-populations. Many are excluding people under the age of 21. In
9 Massachusetts, they are excluding people over the age of 65 who are already in an integrated care program in
10 the state. People receiving home and community-based services in some states are being excluded.
11 People with developmental disabilities who are receiving HCBS waiver services are excluded in Ohio. So
12 you have in your materials another table that adds up, you know, when you exclude these sub-populations,
13 what proportion of the full-benefit dual population is that and what is the remaining eligible population.
14 So that's by way of background, and we wanted to give you some issues to consider, and the main
15 issue would be: Can plans meet the full range of service and support needs of this very diverse enrolled
16 population? To what extent will the demonstration be tailored to meet the needs if a one-size-fits-all
17 approach doesn't work? Will care coordination and care management policies and practices be tailored to
18 meet diverse needs? Will networks be adequate to meet diverse needs? Will the payments be appropriate
19 or appropriately risk adjusted to deal with the enrolled population? Will education and outreach processes,
20 will the materials be geared to these diverse populations? And how will we monitor outcomes for these
21 very diverse groups?
22 COMMISSIONER GABOW: I think another issue that -- this issue just talks about plans, but
23 there are the same issues with fee-for-service. I mean, can they meet the services and support -- can they

1 coordinate across this? So I think there are issues that go with the fee-for-service model as well as with
2 the capitated, and they should be elucidated.
3 DR. O'BRIEN: Yes. In this presentation, we had started with -- we were assuming that we were
4 dealing only with the capitated models, and we sort of leave the managed fee-for-service aside for the
5 moment. But, obviously, many of these issues will apply across the two different financing models.
6 COMMISSIONER GABOW: And I'm not sure that -- well, I mean, I guess it's a choice of what
7 we want to do, but the managed fee-for-service model is problematic, too, and I think not putting that on
8 the table makes it look like the only problems are with the capitated problems, which personally I think that
9 managed fee-for-service has much more problem around coordination and adequacy of support and
10 measurement. So I hope we don't just look at one because it looks like then that we think that the only
11 problems are in that bin.
12 EXECUTIVE DIRECTOR ZAWISTOWICH: And, Patty, we'll be looking at all the different
13 models. We just started with these as there were the greatest number planning to go in 2013, planning to
14 implement in 2013.
15 COMMISSIONER GABOW: And it's fine to be sequential, but I think we should put out that we
16 don't believe that -- we're doing it sequentially for these reasons, not because we think that the only
17 problems to be investigated lie within this model.
18 EXECUTIVE DIRECTOR ZAWISTOWICH: Right. That's a great point. Thank you.
19 CHAIR ROWLAND: But also the target population applies to both models as well, I mean, so
20 that some of these slides do not actually have to relate only to the capitated plan, and so it would be useful
21 to just note where this is an issue and then where it might differ between the managed fee-for-service versus
22 the capitated as an issue.
23 I assume that all of these plans are excluding the dual population that is not the full benefit, that it's

1 only getting the premiums and cost sharing, or are they included in some of these plans?

2 DR. O'BRIEN: My understanding is that the partial-benefit duals are excluded in each state.

3 CHAIR ROWLAND: Because they're often counted in -- when you talk about 9 million duals,

4 you're talking about both sets.

5 DR. O'BRIEN: Yes. I don't think we've done the step-down from a national count to the 26

6 states where we have the four-point...

7 COMMISSIONER COHEN: This sort of previews, you know, because I've looked through the

8 list of issues, but it comes up first here. I mean, a topic is the target population, but the issue about

9 whether the plans can meet the full range of needs, it's really a question of network and providers and doing

10 the real analysis of where this group is served now might not be good, you know, where they're being served

11 now, but, you know, an analysis of where they're being served now, what plans, networks look like and really

12 comparing them. So I feel like some of these issues, like the target population, are not the topics,

13 beneficiary protections, plan standards, they really -- a lot of -- there's a lot of commonality here that boils

14 down to the network appropriateness and the policies around sticking with or changing a provider.

15 DR. O'BRIEN: There's a fair amount --

16 COMMISSIONER COHEN: I kind of feel like that's the cross-cutting major, major, major issue.

17 DR. O'BRIEN: Yes, there's a fair amount of overlap, I think, here, beneficiary protections, raises

18 enrollment issues, target population, but we want to start with this overarching -- CMS has said, obviously,

19 and the states believe this is beneficiary focused, so we start first with understanding who this target

20 population is, understanding the diversity of the needs, and actually we close with that, as you'll see, in a key

21 consideration for moving forward, how do we assure that these demonstrations are beneficiary focused? I

22 think it's a fair point.

23 VICE CHAIR SUNDWALL: Ellen, could I just ask a point of clarification? I should know this,

1 but I was a little confused by the presentation this morning from Sean from CMS. Are these constrained

2 by budget neutrality or not? As he said, they're given relief from that in their innovation programs.

3 DR. O'BRIEN: Right. They do not have to meet the budget neutrality provisions that are

4 typically applied to Medicare demonstrations.

5 VICE CHAIR SUNDWALL: They do not.

6 CHAIR ROWLAND: Except they are supposedly going to have to document savings in order to

7 be approved. So budget neutrality didn't have to save any money, and these are supposed to save money.

8 VICE CHAIR SUNDWALL: So it's an even higher level of expectation.

9 CHAIR ROWLAND: It's a higher test.

10 COMMISSIONER ROSENBAUM: It's my understanding that these do not come in under the

11 CMI, so they're much more held, I think, to the traditional approach to Medicaid demonstrations, which

12 means --

13 VICE CHAIR SUNDWALL: So budget neutrality --

14 COMMISSIONER ROSENBAUM: -- a strong savings, not the CMI, this long-tenure window

15 that they can undertake. It's a different --

16 CHAIR ROWLAND: Well, I believe when Melanie came to our last meeting, she stated that they

17 would have to have documented --

18 COMMISSIONER ROSENBAUM: Right.

19 CHAIR ROWLAND: -- certifiable savings from actuaries to be approved.

20 VICE CHAIR SUNDWALL: Is that your understanding as you're preparing to apply for these?

21 [No response.]

22 CHAIR ROWLAND: But savings is different than budget neutrality because the savings account

23 for both Medicare and Medicaid.

1 EXECUTIVE DIRECTOR ZAWISTOWICH: And budget neutrality in the 1115 context means
2 that the project would not have cost the government any more than the traditional program that would have
3 been in place.
4 COMMISSIONER GABOW: I think we talked about this before, but I think that when we
5 describe the populations, it will be good to talk about how they're being served now, in the sense that what
6 is the coordination of care that exists now. What do we know? I mean, I think we said we don't know a
7 lot, and I think that's important because, again, we're looking at all these things now, but if we don't know
8 how dysfunctional a system is currently, even if the new systems aren't perfect, they may be substantially
9 better than what exists. So I think in this whole thing about target populations, we should try to describe,
10 at least to the degree we have information, what is the current situation, which I think most people would
11 say is far from ideal.
12 DR. O'BRIEN: Right, and our slide on that, our slide on evidence a few slides ago, I think we
13 tried to get at that -- not very effectively -- and promise to come back to it. And, of course, in the
14 evaluation of these demonstrations, states and CMS will have to grapple with looking at the experience prior
15 to the demonstration, during, and once it concludes, yes.
16 COMMISSIONER ROSENBAUM: Can anybody shed light on sort of the logic behind the state
17 choices regarding which populations to include and exclude? I mean, you sort of wonder, you know, why
18 some states are excluding people over age 65, other states are including them. Does anybody know sort of
19 what has led states to make cuts of the populations as opposed to the entire population?
20 DR. O'BRIEN: Key states -- Wisconsin excluding -- I'm going to get this wrong. I need Molly.
21 But -- I'm sorry. Massachusetts excludes people over the age of 65 who are already in a managed care
22 program in the state, Senior Care Options. Wisconsin is focusing on the --
23 EXECUTIVE DIRECTOR ZAWISTOWICH: Nursing home population.

1 DR. O'BRIEN: The nursing home population, again, because the people in the community setting
2 -- so it depends on the existing models, and those people who are excluded are often already in an integrated
3 system. Then there were some choices made obviously not to disrupt people in existing waiver programs
4 and some choices, you know, acknowledging some administrative complexities of dealing with people in
5 California, the share-of-cost population, the state has its difficulty administratively to deal with that as
6 people move through either share-of-cost obligation during the --
7 COMMISSIONER ROSENBAUM: And I assume the under-21 exclusion is children with
8 end-stage renal disease. That's pretty much the duals population there.
9 DR. O'BRIEN: Right.
10 EXECUTIVE DIRECTOR ZAWISTOWICH: And in some instances, some of the states
11 excluded the developmentally disabled population just simply because they were already in care coordination
12 models that they felt very comfortable with, or at least didn't want to deal with at this point.
13 DR. O'BRIEN: And then, of course, there's the whole geographic issue, capacity within the state.
14 Some of them have a geographically limited eligible population.
15 COMMISSIONER ROSENBAUM: It isn't hard to imagine how many people with developmental
16 disabilities would be dual enrollees. Some of this doesn't even make a lot of sense because, generally
17 speaking, they would not have a substantial enough employment history to qualify for Social Security --
18 DR. O'BRIEN: And survivors, right?
19 COMMISSIONER ROSENBAUM: Survivors, that's right. So there'd be a few survivors.
20 DR. O'BRIEN: Okay. The second design feature we identified was enrollment. Most states are
21 proposing a passive enrollment with opt-out under which beneficiaries would receive notification about new
22 plan options, timing notification, meaningful notification about their plan choices, and they would then have
23 the option to make an active choice of a demonstration plan or make the choice to opt out. Those not

1 making such a choice, however, would be passively enrolled and then be able to opt out. But there are
2 certain states who are proposing to CMS that the demonstration include a lock-in or stable enrollment
3 period, including those listed here.
4 So the issues we raise are about the timeliness of the education, the timeliness and appropriateness,
5 you know, content of the education and outreach, will it be adequate to meet the diverse needs of this
6 population? Then issues related to plan assignment. How will the passive enrollment be conducted?
7 What methodology will be used to match the eligible population to plans? Will all plans be eligible for
8 passive enrollment? Will all beneficiaries be subject to the passive enrollment? And what are the specific
9 features of the opt-out process? What procedures/policies will be in place to ensure the promise that this
10 as a voluntary demonstration is realized?
11 CHAIR ROWLAND: Do you know, Ellen, in what sense any of these proposals take into account
12 the fact that a large share of this population has significant cognitive disabilities that to me mean they
13 probably need at least some sort of an ombudsman or an agent to help them through this process? Is that
14 a piece that is built in or ought to be built in to some of these --
15 DR. O'BRIEN: That's a question we've had, and you see reference in the proposals to having
16 culturally and linguistically appropriate outreach that addressed these kinds of concerns, the language
17 concerns and these concerns about cognition, and states certainly have some experience in this regard. It's
18 not an issue that we've really gotten into to understand, you know, how states address it today. But I think
19 it's a fair point. But active choice requires some cognitive capacity to make a choice.
20 COMMISSIONER ROSENBAUM: It seems to me there's also a qualitative difference between a
21 passive enrollment with sort of an immediate adjustment flexibility and a passive enrollment coupled with a
22 six-month lock-in. So I was looking at California, which is using passive enrollment and a six-month
23 lock-in. It's not exactly -- to me, it's kind of an oxymoron. It's not really a passive enrollment. It's

1 you're auto-enrolled into a plan, and you have a minimum length of time you have to stay enrolled.

2 Since the numbers are so large in California, I'm just wondering what have the discussions been like
3 there? How are people approaching the process when you're coupling it with a six-month lock-in? I
4 assume they're going to try and use some sort of -- what's called "smart enrollment" or what.

5 CHAIR ROWLAND: It's called intelligent enrollment.

6 COMMISSIONER ROSENBAUM: Intelligent enrollment.

7 COMMISSIONER CHAMBERS: What do you mean by smart, intelligent --

8 COMMISSIONER ROSENBAUM: Intelligent enrollment where you actually attempt to look at
9 the person's care pattern and attempt to leave the person with the primary care provider the individual is
10 seeing. The numbers are so large in California, and California is taking the most ambitious approach, but
11 I'm just wondering whether we ought not to be thinking about passive enrollment qualitatively differently.
12 You know, is the state coupling it with a lengthy lock-in period? And if so, what are the immediate
13 post-enrollment adjustments or methods that states are using to make sure that if the person's going to be
14 put for six months, the arrangement is correct?

15 COMMISSIONER CHAMBERS: If I could just respond, so California is going to use the linked
16 Medicare data to find, you know, the fee-for-service access patterns, but to have an extended continuity of
17 care period in which the beneficiary demonstrates a relationship with a provider who's outside the delivery
18 system, the plans agree to an extended continuity of care plan, you know, probably beyond the six-month
19 period is to guarantee.

20 COMMISSIONER ROSENBAUM: Well, and I would also assume that in a state like California
21 where group practice, large group practice is so much more common, that the use of these techniques in a
22 place where the system and the underlying delivery system may be somewhat more organized is a very
23 different phenomenon from its introduction, say, in a state like Indiana where you still have a lot of small

1 independent practices and people may not be willing to be in a network.

2 So, you know, you sort of wonder about the market conditions under which these things are being

3 done as well.

4 CHAIR ROWLAND: Richard, in California, as they have moved now with the disabled

5 population that's not the dual population to move them into managed care, are they not using the same kind

6 of matching of providers?

7 COMMISSIONER CHAMBERS: Yes. The easier thing, though, was in the Medicaid-only

8 population is the state had the fee-for-service data in their system in which it's the challenge of matching it

9 up against CMS' Medicare database when you're going to match up the dual-eligible beneficiary and then

10 making sure you're making assignments, because the MediCal system or Medicaid system doesn't have the

11 primary care information and specialist information from Medicare, so it's a little bit more of a challenge.

12 But there's going to be as many accommodations as possible as to make sure that that happens, the linkages

13 going forward.

14 CHAIR ROWLAND: Isn't there a medical exception process for the disability population, too, if

15 they want to remain with their provider?

16 COMMISSIONER CHAMBERS: Yes, and it's the continuity of care, making sure that anyone

17 coming in that demonstrates a relationship with a provider, primary provider or primary specialist, that will

18 continue once that's identified, even if the system in which they're enrolled into does not have a contractual

19 relationship with that provider.

20 CHAIR ROWLAND: Because I know we sometimes think of these things in terms of long,

21 ongoing, chronic care and long-term care services, but I think for some of this population, it could be active

22 oncology treatment. And so, again, the diversity of the population needs to be taken into account.

23 Donna, you had a comment. I'm sorry.

1 COMMISSIONER CHECKETT: I think it's important that as much as we have concerns and it's
2 a new population and lots of new, new, new, states have had a lot of experience, certain states, with these
3 passive enrollment programs, and I heard a concern that was raised earlier about people who aren't
4 cognitively capable of making a choice. Well, people who aren't cognitively capable of making a choice
5 have been enrolled in the Medicaid program for 50-some-odd years, and there are programs in place where
6 you're working with caretakers, et cetera, to address that.
7 I just want to, you know, have everybody remember that there is that type of experience there and
8 to give states a little credit that they might have thought of that or have some ability to deal with it. And
9 also, in terms of passive enrollment, one of the things that I've seen work very successfully when I was
10 running a Medicaid program and we had passive enrollment on a large scale for about five years or more is
11 that the providers were the ones who figured out how to do passive enrollment, a lot of times because they
12 did have a patient, to us a member, for whom it wasn't working for whatever reason, and they were quick to
13 figure out how to do passive enrollment. And I think that's fair.
14 So I just want to raise two issues there, that as we mull through the concerns about passive
15 enrollment, we remember there's a very long history with people with disabilities or cognitive limitations in
16 different types of care management programs, and they have a caretaker who's helping them make their way
17 through that.
18 CHAIR ROWLAND: Okay. Ellen?
19 DR. O'BRIEN: On to the next, the third issue, plan standards and plan selection. What
20 standards will apply to the plans participating in these demonstrations? How will the plans be selected?
21 States under the capitated model are proposing to use managed care organizations to deliver fully integrated
22 services. Plans have to qualify through each state-specific selection process, but plan selection will be a
23 joint process between each states and CMS, and so here are the issues we raised related to at the end of this

1 process what -- how many plans will there be in a demonstration service area and what will be the
2 qualifications of those participating plans, what will be the experience of those plans. Will there be
3 adequate plan capacity if states propose to extend the demonstration statewide? And how will these plans
4 deal with the diverse enrolled population? And then will plan standards for network adequacy for care
5 coordination, for grievances and appeals and so on, be strong enough to offset concerns about passive
6 enrollment? As Sara mentioned, passive enrollment is qualitatively different because there's a lock-in.
7 Ideally, we might want to see those plans being held to fairly strong standards to address those concerns.
8 And since this is an integrated approach, how will differences in Medicare and Medicaid plan standards be
9 aligned? And which standards will apply or how will they be merged? What will this mean for quality
10 assurance and how it works today in Medicare and Medicaid? What will it mean for appeals? The state
11 proposals tend to suggest -- and CMS -- that there will be an integrated appeals process, but we don't know
12 yet how they will draw elements from the Medicare and Medicaid appeals process to create this unified
13 appeals system.
14 COMMISSIONER COHEN: This is not really a question, but it's just sort of a repeating of what
15 I think we have all come to understand around this table, which is that this question of plan standards is so
16 critical that there's like no really great source for what are good plan standards that result in good results.
17 And I guess I think it's an area that MACPAC could play a substantial role in trying to distill some lessons,
18 best practices, and other sorts of things. I'm sure there are other sources for it, too, but it just seems like
19 it's a -- it feels like there are not authoritative sources for what are good plan standards and what are good
20 ways of ensuring that plan standards are met, so, you know, that's sort of an enforcement management
21 piece, too. So it's one thing to say that you need good plan standards, but I don't know that we know how
22 to judge them necessarily or that we have a common way of judging them.
23 COMMISSIONER CHAMBERS: Just to disagree a bit, a number of states and Medicaid

1 programs have had experience in the ABD population so they do have experience and standards in
2 contracting with plans.
3 For the dual population is we can't forget is that there's been the special needs program in Medicare
4 for a number of years, and California's experience, what's going to happen with most of the counties, that
5 they're going to have the plans in, the plans currently are dual-eligible SNP programs and having performing
6 since -- most of us since back in 2005. And the process that CMS goes through is quite rigorous.
7 Now, the one caveat is that it's just on the acute-care services side, which is the difference in these
8 demonstrations when you add the long-term care services in and support services, which a lot of plans, you
9 know, on the Medicaid side no one's had much experience with. And so that's sort of the big question
10 mark, particularly when you get to the network adequacy and care coordination stuff, when you go beyond
11 acute-care services.
12 So I would think as there's a lot of stuff out there and there is state experience, but we're in a
13 different --
14 COMMISSIONER COHEN: Can I just respond to that really quickly? So I totally agree with
15 you. I think by saying what I was saying, I wasn't saying that there isn't experience and even good
16 experience out there. I think what's missing is a common understanding across, you know, various
17 stakeholders and across states as to what those are, you know, sort of like a common identification of them.
18 I have no doubt -- I actually think in -- and, you know, New York has some really excellent practices that I
19 think, you know, have proven themselves to be excellent. But if you ask me how have they proven
20 themselves, could I convince you in a language of sort of data and objective evaluation and all those things,
21 maybe I could, maybe I couldn't. I think it's this sort of lack of common understandings and a lot of CMS
22 work that is very ad hoc, you know what I mean? Sort of taking each state's existing infrastructure, trying
23 to sort of move it to the next level or whatever, but there's, again, just sort of a little bit of a lack of a

1 national common understanding of some best practices.

2 CHAIR ROWLAND: Richard, your comment also provoked me to think that we also ought to

3 look in our data at how many of the duals actually use long-term care services, because I think it's

4 commonly sort of talked about as if every dual uses long-term care services, but we do know that some of

5 them are primarily duals because they're very low income and they have more acute-care needs and perhaps

6 don't use that. And so in your analysis of the diverse population looking at the nursing home versus the

7 community-based long-term care versus the acute-care-only duals would be a really good way to do that data

8 analysis.

9 COMMISSIONER ROSENBAUM: On the appeals issue, I think this is an area where sort of

10 conversely there's a boatload of stuff. I don't know that any of it is outcomes driven, whatever that means,

11 and we're talking about an intensely legal issue, so I'm not quite sure that the issues have played out sort of

12 as in classic empirical forms as much as, you know, disputes over systems. And there are some

13 bottom-line legal safeguard matters that come up, but I think it would be worth it for us to keep our eye on

14 two issues, and having looked at the CMS guidance when it first appeared on this, I was actually surprised

15 that they really hadn't done a lot of thinking on this issue.

16 So there are two kinds of appeals. There are appeals that are driven by a lot of medical evidence,

17 and there are appeals that have to do with no medical evidence whatsoever. Somebody has a dispute over

18 the meaning of your coverage, you know, you hit a limit, and all the medical evidence in the world isn't really

19 going to help you because you're disputing a purely legal question.

20 And then the other big issue is whether -- and this is where, you know, we're up against things that

21 rise to the level of a constitutional consideration, but whether you continue paying for treatment while the

22 dispute is being resolved. You know, it's what we all call sort of in the vernacular aid paid pending. But

23 we ought to, I think, in our own writing about these issues, we ought to -- as we begin to develop them

1 more fully, we should pay attention to this because it goes to the integrity of the resource allocation system;

2 that is to say, when there are complex questions of evidence, you want it done quickly and you want it

3 developed fully and fairly, and that may mean actually a much greater emphasis on the internal appeals

4 process than is currently given. You may want the plan to do certain kinds of evidentiary development

5 with an impartial internal review.

6 When it's a straight up question of I want X, well, no, you're not covered for X, then you really don't

7 want the plan wasting a whole lot of time on it. There's a different kind of dispute underway.

8 This has received so much attention in employee benefits and so much attention over almost 50

9 years that I think we would be doing a service to actually develop this body of evidence more. You're not

10 going to run empirical studies of which is the correct set of decisions as much as at least gather together

11 what the thinking has been to try and come up with a rational system, and particularly this question of when

12 do you continue treatment, at least for some period of time, while you're resolving a dispute, and when do

13 you say this decision can go into effect immediately.

14 COMMISSIONER GABOW: I hate to sound like a broken record, but I will. When we talk

15 about this plan standards, I think we have to get back to right now the uncoordinated fee-for-service.

16 There are no standards so -- or very few. Maybe "no" is too strong. So it's against what benchmark, and

17 I think we have to keep coming back to that because, otherwise, we can get tied up in knots about, well, are

18 these enough? Well, they're certainly more than zero, and things have got to be incremental. And I just

19 don't want that to be lost in this discussion.

20 Now, it is a movement towards more coordination, more accountability, more standards rather than

21 moving from something which had a very mature, very sophisticated set of standards and benchmarks, and

22 we're going away from that. And I think we don't want to miss that point because it changes the dynamics

23 of the discussion, I think substantially.

1 CHAIR ROWLAND: But the payment method is also changed, and so you have the issues of
2 what standards to go with a capitation payment that are different than the fee-for-service case management
3 payments. So we have to keep that in mind when we get to payment.
4 David, did you --
5 VICE CHAIR SUNDWALL: No. I'll wait until evaluation.
6 CHAIR ROWLAND: All right. Beneficiary protections.
7 DR. O'BRIEN: Well, I don't want to sound like a broken record, but here we are back again at
8 beneficiary protections, picking up some of the issues we've already discussed but bringing them together to
9 emphasize yet again that it will be important to understand what core beneficiary protections are in place.
10 A core protection is clearly that the demonstration is voluntary in the sense that it's passive
11 enrollment with opt-out. There is a capacity to opt out, although it may be limited in the states that have a
12 lock-in.
13 Another core beneficiary protection is that new enrollees should have a choice of at least two
14 managed care plans. CMS has indicated, touching back on these plan standards, that Medicare Advantage
15 requirements are a floor and that their preferred requirements are those, and that they'll engage in
16 negotiation with states over what the requirements will be in each demonstration state.
17 Other protections include requirements related to models of care, assessment and care planning,
18 timely notification of beneficiaries about their plan choices, about claims and such, and about appeals
19 processes.
20 So the issues that we've raised are, you know: What will the policies and procedures for opt-out
21 be? Will they be sufficient to guarantee that's a real option for people? What about continuity of care?
22 I think we've already discussed this a little bit, that dual eligibles who are in the midst of treatment or are
23 receiving the services from existing providers who may not be in a plan network, there needs to be a

1 transition for those to assure the continuity of care and that those relationships are preserved for some
2 period of time.
3 There's an issue related to the adequacy of the care management, how beneficiaries will know how
4 to access those services and other services under the plan. And then, again, we mentioned this idea of the
5 appeals process as a crucial beneficiary protection.
6 CHAIR ROWLAND: What happens if a plan pulls out in the middle of the year? Can they do
7 that under this demo? I mean, I know that it has happened where the state has either shut down a plan -- I
8 mean, that was one of -- when Tennessee reflected on its experience and said you always need to have a
9 backup plan.
10 COMMISSIONER CHAMBERS: The only thing I can think of is because they're using the
11 Medicare cycle, the calendar year cycle for the start of the program and why Melanie has resisted to having
12 enrollment on a different cycle than on an annual basis because of the informing in the fall, et cetera, I
13 would assume that plans couldn't voluntarily disenroll from the program except on an annual --
14 CHAIR ROWLAND: Until the following year.
15 COMMISSIONER CHAMBERS: That's what I would guess, unless there was some financial
16 issues or, you know, the plan had to be shut down. But I'm just guessing. I haven't heard that discussion.
17 COMMISSIONER CHECKETT: I would just concur on the Medicare side that your company is
18 signing the contract with CMS to provide the service for a year. I don't know what the consequences are
19 of not being able to do that, but I'm certain they are extensive. In a good state -- we've talked about good
20 processes that we've learned. A good state-managed Medicaid contract will also have contractual language
21 that deals with plans both when a state needs to shut them down and when a plan says, "I can't do business
22 anymore." And there should be -- and, Sara, I'm certain I know you've looked at a lot of this, but there's
23 usually standard language in all those contracts that establish when you can and can't do that and how that's

1 done. Critical beneficiary and state protections in both cases.

2 DR. O'BRIEN: Okay.

3 COMMISSIONER HOYT: Are you taking comments or questions on beneficiaries now in

4 general?

5 CHAIR ROWLAND: Yes.

6 COMMISSIONER HOYT: So we did all this preparation on the access chapter or chapters for

7 the June report, and it seemed in that instance we were largely informed by two national surveys, and it got

8 me to thinking. Are there any plans to survey the beneficiaries here? It would seem like a natural

9 component maybe of program evaluation to ask them, you know: Do you feel like you're better off? Did

10 you have problems with enrollment? Other different things that we've touched on here. It just seemed

11 like a natural fit.

12 DR. O'BRIEN: I'm not sure if a beneficiary satisfaction survey will be a requirement of plans, but

13 it will certainly be a component, I would imagine, of the evaluation of the demonstrations.

14 EXECUTIVE DIRECTOR ZAWISTOWICH: And, Ellen, I think CAHPS is required.

15 DR. O'BRIEN: Okay.

16 CHAIR ROWLAND: Okay.

17 COMMISSIONER HENNING: I just have a question on how are these plans certifying that they

18 actually have tried to get a hold of the person that's enrolled and given them a choice, because I have so

19 many people that show up in our office thinking that they have the proper insurance to be seen there and

20 get told, "We don't take that plan. You have to switch to something else." And until they can switch to a

21 different Medicaid managed care company, then we can't see them.

22 DR. O'BRIEN: The state is making the initial notification to beneficiaries of their enrollment

23 choices, not the plan, and then there are requirements on the plan to have contact with the beneficiary --

1 with the plan enrollee within a certain period of time, I believe, to undertake a health risk assessment.

2 COMMISSIONER HENNING: But I guess my point is that a lot of my patients are very hard to

3 get a hold of. They are either migratory in that they move from town to town, or they're migratory in that

4 they move from house to apartment to house to apartment to trailer park. You know, it's like they're not

5 in the same place for three months at a time.

6 DR. O'BRIEN: I think this is another one we have to draw on the extensive knowledge around

7 the table that a state experiences with effective outreach to these sometimes-hard-to-reach populations.

8 It's an issue we should look more closely at.

9 COMMISSIONER SMITH: Well, I'm going to follow up on Denise's comment because I agree

10 that there's all kinds of reasons why beneficiaries may or may not -- they may actually get the letter and think

11 it's junk mail or not understand it's something important that they need to respond to.

12 There are people with cognitive disabilities who sort of are on that order where they may be able to

13 make day-to-day decisions for themselves, but they may not have the capacity to understand the complexity

14 of what they're being asked to choose. And so I think we still have an issue with people who have some

15 type of cognitive disability, and, yes, they've been in the program for a very long time, but there have also

16 been a lot of problems around that. So I think we still have a problem with that.

17 I would like to get a little more in-depth about how the states will be contacting beneficiaries and

18 making sure that there is actually a response, even.

19 DR. O'BRIEN: And we will have some capacity to evaluate whether states and plans are doing a

20 very good job because CMS will collect data, will require states to submit data on exactly how many were

21 passively enrolled. If in a state a large number make an active choice, that would be a good indicator

22 perhaps that they got good information and maybe that the plan choices appealed to them. And others, if

23 we see opt out early on in the early months, might raise questions about what they knew and when they

1 knew it.

2 COMMISSIONER SMITH: Well, I just wanted to say sometimes the people who are in the
3 position of making the contact and making the offer may have a -- I don't want -- I'm not -- they may want
4 everybody to opt in, and so it may not -- they may not make a great effort. Unfortunately, historically, that
5 has happened, at least in my state, and there just wasn't a great effort made to contact people, and it wasn't
6 the duals. It was other populations. And, you know, it scares me that there are going to be people who
7 are not going to be reached, and they're going to opt in, and they're not going to have the opportunity to opt
8 out.

9 COMMISSIONER COHEN: Can I just make the point on that that there's two ways of looking
10 at that issue, which I think is a really real issue? One is to make sure that the outreach is as effective and,
11 you know, that real standards are applied to it and all that. But the other is to figure out if you can't reach
12 everyone or everyone is not capable of making a really well-considered choice at the point that the choice is
13 in front of them, sort of thinking about how to mitigate the consequences of that. You know, a lot of the
14 time the plan choice is really most relevant to who your providers can be, and there are strategies to try to,
15 you know, mitigate that, like if you opt into a plan but you have an existing provider relationship that's not
16 just on paper who you're assigned to be someone you've really been seeing and that sort of thing, there are
17 strategies to say that the new plan has to in some way help facilitate continuity of care with that provider;
18 otherwise -- I mean, all of those kinds of policies have trade-offs, but at the same time, I actually think, you
19 know, best practice is probably not to assume that every single person is going to make the very best really
20 consequential choice for them at the right time, but to make sure that there are other protections down the
21 line for in case they make not the right choice, that that can still be addressed.

22 COMMISSIONER SMITH: And I am very comfortable with -- I mean, I feel like we have really
23 good questions here that are going to be answered. I feel very comfortable about a lot of what's going into

1 this, so I can see that it's all going to be worked out as long as we do have really good protections for the

2 beneficiaries. I think that's critical for me.

3 CHAIR ROWLAND: Okay. Ellen?

4 DR. O'BRIEN: Okay. Next we have financing and payment. We've gone through some of

5 these already. I'll go through it quickly. The Medicare and Medicaid financing streams will be integrated

6 at the plan level, and as we mentioned, the prospective blended payment will build in up-front savings to

7 both CMS and the states. CMS will work with an actuary and develop the methodology for establishing a

8 baseline spending figure and calculating savings, working on that with each state.

9 A number of issues arise. We don't have a lot of information yet about how baseline spending will

10 be measured across and within states, and what the savings opportunity will be, what methodology will be

11 used to estimate the savings that will be generated in the integrated plans, how will those savings then be

12 allocated between CMS and the states and how will they be used.

13 Maybe I'll just go quickly to payment and then participating plans, again, paid on a capitated basis.

14 The rates will be developed based on that baseline spending and savings assumptions, and the capitation

15 payments will be made directly to plans rather than flowing through the States.

16 Again, the issues are related to how the Medicare payment approaches will be developed for the

17 demonstration, whether they will, for example, vary by State under the demonstration or whether they'll be

18 uniform; what risk adjustment methodology will be used, especially for the Medicaid portion of the

19 payment, will there be adjustments for frailty or functional status or the use of Medicaid services such as

20 home and community-based waiver services; and potentially what risk sharing may be incorporated into the

21 demonstration and how will it be operationalized. Some States, for example, have proposed risk corridors,

22 and I don't think we know yet what decisions CMS might make on risk sharing.

23 So there's much yet to be known about these aspects of the demonstration. We'll be watching

1 them quite closely.

2 CHAIR ROWLAND: Trish.

3 COMMISSIONER RILEY: Can you say more about the capitation payments? Does that

4 assume the Medicaid and Medicare payments will be blended and paid by the Feds?

5 DR. O'BRIEN: They will be blended. They will flow as a single stream to a plan --

6 COMMISSIONER RILEY: So that's --

7 DR. O'BRIEN: -- but I didn't think that, operationally, that the Feds would pay it, but --

8 COMMISSIONER RILEY: Not through the -- okay. Capitation payments will be --

9 DR. O'BRIEN: There was some concern that if the funds were to flow to the States, the States

10 might divert a portion of those funds for other uses, so Melanie, I think –

11 COMMISSIONER RILEY: So is that the full capitation for the full, or is it just the Medicare

12 capitation?

13 EXECUTIVE DIRECTOR ZAWISTOWICH: Trish, from what we could gather with talking to

14 the States, I think it's unclear yet. Both the payment method still needs to be worked out as well as the

15 process for the funds flow.

16 CHAIR ROWLAND: And for the savings.

17 EXECUTIVE DIRECTOR ZAWISTOWICH: And for the savings.

18 CHAIR ROWLAND: I think, Trish, you are raising a question of how does the money get to the

19 plan and we're not sure.

20 COMMISSIONER RILEY: [Off microphone.]

21 DR. O'BRIEN: On oversight and program accountability, CMS and the States are to determine

22 applicable quality standards and jointly conduct a comprehensive quality management and reporting process.

23 CMS has indicated that a CMS State contract management team will ensure access, quality, program

1 integrity, and financial solvency. Another element of program accountability and oversight is that plans

2 will be subject to an increasing quality withhold of one, two, or three percent in years one, two, and three.

3 So --

4 CHAIR ROWLAND: The quality withhold is by CMS? So that would indicate that the payment

5 would be coming from CMS.

6 DR. O'BRIEN: Yes. Oh, is that a Medicare quality withhold? I'm looking -- sorry. That was

7 unclear here, that this is Medicare quality withhold. So it's coming from Medicare and States would have

8 the capacity to earn back a portion of the Medicare rate if they meet quality standards.

9 CHAIR ROWLAND: Sharon.

10 DR. O'BRIEN: Of the withheld portion.

11 COMMISSIONER CARTE: So the plan would be reporting measures, I assume --

12 DR. O'BRIEN: Mm-hmm.

13 COMMISSIONER CARTE: -- and then that withhold would be brought back to the plan if they

14 meet an improvement level or a certain --

15 DR. O'BRIEN: Right.

16 COMMISSIONER CARTE: Okay. Thank you.

17 CHAIR ROWLAND: David.

18 VICE CHAIR SUNDWALL: I've been trying to figure out where to best make this comment. I

19 made it earlier and it bears repeating.

20 Somewhere in our report, we ought to acknowledge the importance of public health parameters in

21 quality measurement, and I don't think it's apparent. Maybe it's just taken for granted. Maybe health

22 plans are so accustomed to requiring proper immunizations or screenings or smoking cessation, obesity,

23 whatever, but it's particularly relevant for this vulnerable population. Something as simple as the new

1 herpes zoster vaccine to prevent shingles can save enormous amounts of grief and personal suffering as well
2 as some costs, Pneumovax, flu vaccines, screenings recommended by the National Preventive Health
3 Services Task Force. These are simple things to measure and I think the payoff is significant. Additional
4 things like smoking cessation, obesity, and now in this context of the day, opioid addiction,
5 over-prescribing, dependency, death, these are relatively simple measures and I think, while I know people
6 at CMS are sympathetic with this, unless it is explicit as a quality measure, I think we -- they need to make
7 that clear because there are things they can document and measure.
8 Like I said, there's a recently published -- March of this year -- IOM report on integrating public
9 health and primary care that's really good data to support this recommendation.
10 COMMISSIONER HENNING: David, I just have a question. Does Medicaid even pay for
11 vaccines for adults, because we're trying to get TDAPs for pregnant women and Medicaid won't pay for it in
12 my State.
13 VICE CHAIR SUNDWALL: Yes, they do. I mean, I don't know if that's a State -- it's an
14 optional benefit, but States -- many States do. I don't know what Florida's situation is. I mean, for
15 heaven's sakes, Texas was even going to mandate they cover Gardasil and that backfired a little bit. But,
16 yes, they do pay for -- they can and they should.
17 And as far as the ACA, it now even made a requirement that all private plans starting last September
18 must cover these services. So this is where services --
19 CHAIR ROWLAND: Except it didn't extend it to Medicaid.
20 VICE CHAIR SUNDWALL: It did not? Isn't that odd. So it did not extend that to Medicaid
21 as a requirement, but for private plans. So I think if they're going to look at this vulnerable population and
22 look at some public health measures that are proven over time, there's a lot of evidence based for this, so I
23 think we ought to be on record as recommending that be a measure.

1 CHAIR ROWLAND: David, I think also in a separate, unrelated to the duals, piece of our work,
2 we ought to really look at the availability of preventive services measures within the Medicaid program --
3 VICE CHAIR SUNDWALL: Absolutely.
4 CHAIR ROWLAND: -- because it was a specific omission or deliberate omission to not apply the
5 preventive services that are guaranteed in all the private plans to the Medicaid program.
6 VICE CHAIR SUNDWALL: Well, I guess I'm the only clinician on the committee and I see the
7 benefit of this every week. Oh, I'm sorry. I beg your pardon. We two are clinicians.
8 CHAIR ROWLAND: We've got a few others.
9 COMMISSIONER ROSENBAUM: You should note, in the case of pregnant women, there's a
10 pretty good argument to be made that it's a pregnancy-related service where it's part of the standard of care
11 now in obstetrical practice, quite apart from whether the woman, if not pregnant, would be covered. For
12 example, CMS treats immunizations that are part of a routine family planning visit now as integral to the
13 family planning visit, so it's sort of the same issue. So when we do this look, I mean, we may want to think
14 about the different ways in which you cut the question. But it's clearly, for pregnancy-related care, it
15 should be --
16 COMMISSIONER HENNING: They don't pay for a flu vaccine.
17 CHAIR ROWLAND: Okay. Robin.
18 COMMISSIONER SMITH: When Sam was in the medically fragile program that we had up,
19 which was like a -- it was a managed care program -- they had the option to not only give the children the
20 vaccinations, like for the flu and pneumonia, but also the parents, and they would go to the entire family and
21 they would give the entire family -- and many of those were foster families that had private insurance,
22 probably, somewhere. But because they were in the program, they wanted to make sure those kids were
23 safe for the winter. They would make sure that the entire family got the vaccinations and it came from that

1 program, which makes me ask the question, under these managed care programs we're talking about, demos,

2 do they have flexibility within -- I mean, normally, Medicaid may not pay for adult vaccinations, but under

3 the managed care plans, would they have the flexibility to do that?

4 CHAIR ROWLAND: I don't know.

5 COMMISSIONER ROSENBAUM: You can go outside of the normal coverage rules. That's

6 one of the benefits of managed care, that you can provide things that would not be covered in a

7 fee-for-service context. It's one of the great strengths.

8 COMMISSIONER SMITH: I think that needs to be hammered home, too. There are a lot of

9 strengths in that area, not just the vaccinations and public services, but sometimes it's diapers,

10 over-the-counter medications, things like that, that can really make a difference.

11 CHAIR ROWLAND: Or even retrofitting houses so that people don't fall in them.

12 Okay. Ellen.

13 DR. O'BRIEN: Okay. Issue 8, Implementation. A number of States are proposing to

14 implement the three-year demonstration January 2013. A few have delayed their implementation date to

15 2014, but States' readiness to implement the demonstration and plans' readiness, CMS readiness, is an issue.

16 CMS has hired a contractor to conduct readiness reviews in these States, but the issues we raise are how will

17 CMS, the State, and demonstration plans each ensure that they are ready for implementation, and what, if

18 any, phased-in implementation strategies are States proposing? And we have seen in these proposals that

19 there are States who are proposing to roll it out by region or by population group, but would hope to see

20 the demonstration begin only when readiness is determined.

21 In terms of evaluation, then, how will we know if the demonstration has succeeded? CMS has

22 hired an evaluation contractor to design and conduct an evaluation of the demonstration and States, to

23 some degree, have included some information on evaluation in their proposals. The issues are how will we

1 assess the pre- and post-demonstration experiences of dual eligibles? How will those experiences be
2 measured and evaluated? How will we know that the demonstration has achieved its goals? And how
3 will success be defined in order for the Secretary to make a determination that the demonstration can
4 continue and be extended in other States?
5 CHAIR ROWLAND: In some of our earlier work, we looked at the fact that some evaluations
6 take five years or so to come out with their results and need for rapid feedback on some of the provisions
7 here. And I think, given the critical nature of this population and how vulnerable they are, that building in
8 some feedback loops for the program as it goes along so that there can be just adjustments -- I know
9 evaluators really like to not have it changed from the baseline, but I think what we want is to see that the
10 beneficiaries get the best care possible and some kind of feed loop might be a place where we -- feedback
11 loop where we would recommend they have that as well as the formal evaluation.
12 DR. O'BRIEN: I think that's what motivates some of the State -- discussion in the State proposals
13 about evaluation, that it really is about monitoring performance and continuous quality improvement as the
14 thing proceeds rather than this just --
15 CHAIR ROWLAND: And hopefully also, then, sharing with other --
16 DR. O'BRIEN: Right.
17 CHAIR ROWLAND: -- States. If you're implementing in 2013 and you've figured out a few
18 things that just don't work, that those get out before they get built into the design of other States.
19 COMMISSIONER RILEY: And that the evaluation design doesn't become paramount to change,
20 because it may be that the States find part -- and this has happened -- partway through, you find out you
21 have to change directions. It completely messes up the evaluation. You would not want an important
22 change to be stopped because the evaluation will be compromised, and I think that needs to be part of this.
23 DR. O'BRIEN: Okay.

1 CHAIR ROWLAND: Other comments. Judy.

2 COMMISSIONER MOORE: I just have a question sort of generally. The issues and questions

3 that you've raised are all incredibly important, and I'm wondering if they're kind of general or if they're

4 based on reviewing things and saying, gee, something's not here, because I had understood that there had

5 been a fair amount of discussion around quality standards and payment and risk adjustment and so forth,

6 but I don't know that that's, you know, out in written documentation form. So I'm wondering how much

7 CMS has actually done or has some of the answers to these questions or issues that we don't necessarily

8 know or sort of what that looks like.

9 EXECUTIVE DIRECTOR ZAWISTOWICH: I think, in some instances, CMS does have

10 answers to some of these questions, but it's a question of the extent to which they apply in all these

11 circumstances.

12 COMMISSIONER MOORE: Yes.

13 EXECUTIVE DIRECTOR ZAWISTOWICH: In other areas, I think CMS recognizes that

14 additional work needs to be done and that they will be setting forth guidance as the proposals are --

15 COMMISSIONER MOORE: As they along.

16 EXECUTIVE DIRECTOR ZAWISTOWICH: -- as they go along. I think there are certain

17 areas, especially when it comes to the rate setting and the payment, where additional work clearly needs to

18 be done, and I think CMS would acknowledge that those areas still need additional clarification.

19 CHAIR ROWLAND: Okay.

20 DR. O'BRIEN: All right. We just have a final slide on key considerations, bringing these themes

21 together. As CMS develops State-specific memorandums of understanding, the design and

22 implementation of the demonstrations should adhere to certain key principles, and we set them out here as

23 beneficiary-focused. Demonstrations must be beneficiary-focused with strong beneficiary protections.

1 Plans must be able to meet the diverse needs of the populations that are enrolled.

2 Second, readiness and sustainability. Demonstrations must be sustainable. For example,

3 payments must be adequate to ensure that the plans succeed. Implementation should proceed only when

4 CMS, States, and plans are ready. Beneficiaries must also be ready with timely and meaningful notice.

5 Transparency. We think it may be important for CMS, States, and plans to share information

6 about the design and performance of the demonstration, including information on payments, the

7 methodology used to determine savings, and the allocation of those savings. MACPAC is a keen observer

8 and others will be, as well, and people -- various stakeholders will want to be informed about these design

9 details.

10 And finally, accountability. CMS and the States must ensure the appropriate use of State and

11 Federal funds. These are probably considerations for the implementation of any major change in health

12 care delivery and payment, but we think they are especially important here and are worth reiterating.

13 CHAIR ROWLAND: So given our earlier discussion and Patty's comments, we're going to look

14 not only at the capitated model but at what here applies to the fee-for-service case management model.

15 We're going to also try to pull together whatever evidence there is of how Medicaid has handled these issues

16 in the past, what experience is there, what fine tuning has been there. And I assume we'll be trying to pull

17 this together into an issue brief that could be the beginning of either comments that we would make or just

18 a summary of the topics and some of our discussion. Is that the direction that the Commission members

19 would like to proceed at this point? Trish.

20 COMMISSIONER RILEY: I think that direction makes lots of sense.

21 One issue that jumped up at me as we went through Ellen's presentation was sort of the nuance of

22 State versus Federal. There's so much focus on what the States are planning to do. And it's also -- it's a

23 Federal-State partnership that's unique and in and of itself is a demonstration. So I wonder if it might not

1 be wise to flesh out the questions a little bit differently. I just made a couple of -- there were a couple of

2 things that jumped out.

3 One is I'd almost like to see what States proposed that the Feds reject, just to see what they were

4 thinking that wasn't possible from a Federal perspective because it might be interesting in later evaluation.

5 The issue of that already we know because of Medicare we have to have open enrollment, and that

6 will challenge some of the States' timing in their start-up. We already know that there are Medicare data

7 issues that are going to complicate passive enrollment. So some of these are Federal issues that are going

8 to confound what States want to do.

9 Plan standards -- how are they set? Is the Medicare Advantage a reasonable floor? Could there

10 be a different plan standard? CMS and States will jointly determine and review quality standards. Hmm.

11 What if there is a disagreement? And particularly, what if there is a disagreement when the Federal

12 Government is paying the plans directly? It goes back to sort of the notion of one plan of care that's

13 administered as one plan of care with the sub-components beneath it and it's managed by one entity in

14 order to make sure that there's consistency in what goals we're trying to achieve.

15 So I think some kind of a playing out of these issues. There's a set of policy issues around

16 Medicare and CMS. There's a set of State issues about what they propose. There's a natural conflict.

17 And just to be able to know as part of our baseline, what did the States want to do that they couldn't do?

18 And I'm not making a value judgment about whether that's good or bad, but it will be interesting as we go

19 forward to see, were there some barriers that were presented early on that we didn't overcome that maybe

20 we should have or that are identified later. So I think there's a richer conversation here.

21 CHAIR ROWLAND: And also, I neglected to say, we also want to start the beginning with where

22 we are today and what some of the lack of coordination in the system looks like so that we have a

23 benchmark to compare whatever changes occur.

1 Okay. Well, thank you very much, Ellen.

2 Lois, I think we're going to move on to our report for June and our look at data sources for
3 measuring access to care for Medicaid and CHIP. We've talked a lot about data, specifically on the duals,
4 but this is another area where, once again, data can confound our ability to be as analytic as we would like.

5 **### CHAPTER REVIEW: DATA SOURCES FOR MEASURING ACCESS TO CARE FOR**
6 **MEDICAID AND CHIP**

7 MS. SIMON: Good afternoon and thank you.

8 So, today's session will provide an overview of the Draft Section, "Measuring Access to Care for
9 Medicaid and CHIP" for the June Report. I look forward to getting your feedback and guidance to the
10 proposed section.

11 CHAIR ROWLAND: And we're at Tab 4; is that correct?

12 MS. SIMON: Yes.

13 As we discussed at the April meeting, this chapter provides information on a number of data sources
14 and activities that could be part for monitoring access for Medicaid and CHIP enrollees.

15 Monitoring access is not only critical for detecting existing, emerging, and potential issues in the two
16 programs, but also for providing information on whether the programs are purchasing effective, efficient,
17 and timely care, and achieving value for the care that is being provided.

18 In this Section, we highlight MACPAC's access framework, suggesting that it be used as the
19 foundation for a monitoring approach.

20 We also present a number of criteria to assist policymakers in the creation of an effective access
21 monitoring system. These criteria including complimenting existing and well-tested efforts and avoiding
22 duplication; being both proactive and reactive in order to anticipate where issues may arise, detect problems
23 as they emerge, and be able to respond promptly; to give consideration to economic, demographic, and

1 social factors that may frame or impact health care delivery or policies; to use data that can measure access
2 in both managed care and fee-for-service in rural areas and urban areas among different groups of enrollees
3 and, when possible to link data that will link access to both health outcomes and quality; and also, to include
4 a mechanism for providing feedback between states, providers, and the Federal Government.
5 So, when combined as a set, selected measures should present an accurate picture of access for the
6 program, enrollees, or the geographic area that's being assessed. And therefore, access monitoring should
7 be ongoing and it should focus on both the immediate and the long term.
8 A key element of an access monitoring approach is the detection of issues in as real time as possible.
9 A number of activities are highlighted that focus on providing relatively rapid and immediate identification
10 of emerging issues. These are activities that have the potential to detect localized issues in a timely manner.
11 They include the tracking of complaints, grievances, and other issues through hotlines, use of focus
12 groups and enrollees and providers, secret shopper calls to providers, and really just overall frequent
13 communication streams with advocates, providers, enrollees, and other stakeholders.
14 It is also monitoring on a regular basis changes to Medicaid enrollment and changes in service use.
15 And lastly, it's considering whether potential exists for using a group of sentinel providers such as
16 emergency departments or safety nets for detecting changes in patterns of care within a given community.
17 There are also a variety of sources that could serve as platforms for building a longer-term tracking
18 approach for measuring access to Medicaid and CHIP, and these include administrative data sources such as
19 claims data and encounter data, provider network and quality requirements that are included in states'
20 contracts with their participating managed care plans, results from national household and provider surveys,
21 and lastly, HRSA designation for health professional shortage areas and medically under-served areas which
22 you will hear about in the next session, could possibly assess with monitoring.
23 So, the Section highlights a wide variety of activities and data sources that could be considered for

1 inclusion in an access monitoring approach. Each needs to be assessed on their strengths and their

2 limitations, their feasibility and costs, and how suitable they are for creating state and local level

3 measurement of access and how, when combined, the information gained will help to create a picture of

4 access as a whole.

5 So, I thank you and I look forward to your feedback on the chapter, any comments.

6 COMMISSIONER ROSENBAUM: Well, this issue came up for me last time, and it still

7 continues to weigh on me this time, which is, is our job to document that people don't have access or is our

8 job to try and determine the utility of different approaches to improving access, two different visions?

9 And the reason I keep coming back to it is because we're about to hear from, of course, HRSA,

10 which has designated I don't know how many thousands of communities that, by Federal definition, are

11 medically under-served either because they have a shortage of professionals or they have people with poor

12 health outcomes or a combination thereof.

13 And so, I'm wondering -- I realize it is sort of a different way of looking at what we are doing in

14 monitoring access, but the same issue arose for me with the regulations on access, which is whether we

15 should be investing more of our time in doing what I think of as sort of documenting the obvious versus

16 putting our time into the effectiveness of various interventions to increase supply, to improve continuity of

17 care, to up the frequency with which certain kinds of services that we know are evidence-based, value

18 services are used. And maybe that would be, in the long run, a greater contribution to this overall

19 enterprise than simply saying, "Yessiree, if you're in an area that's been designated as a HPSA you have an

20 access problem." I mean, that much we know.

21 CHAIR ROWLAND: Stop the conversation. That's a hard question.

22 Next question. Steve, bail us out, here.

23 COMMISSIONER WALDREN: Well, I mean, I think the issue is the second, because you can't

1 improve what you don't measure. So, I think we have to do, at some level, measuring what access there is,

2 but really focus on that.

3 So, I mean, how specific do we have to get on the measurement of access, and I think the notion of

4 the medically under-served areas saying, "Yeah, there's an access problem there." But then, if that's the

5 only way that you look at access the only -- in my opinion, the only solution is to have more providers in

6 that area, but that may not improve the access.

7 COMMISSIONER ROSENBAUM: Right, but they don't see Medicaid [off microphone.]

8 COMMISSIONER WALDREN: Yes. So, I mean, but I think you have to do that, the

9 measurement.

10 I think the real question is how much -- how specific and how detailed do we need to get before we

11 start dealing with some of these access issues.

12 COMMISSIONER ROSENBAUM: I guess my question is, are we really going to second-guess a

13 HPSA designation, whatever the formula finally is for measuring HPSA or an MUA designation?

14 I realize we're going to hear the complexity in the next session. We're going to hear the complexity

15 around measuring shortage. This is not an easy thing to do, but there's a whole arm of the Federal

16 Government that is -- whose job is to measure at least primary care shortages. Now, we might want to

17 focus on shortages that are not captured for specialists, for residential placements -- I mean, things that the

18 MUA HPSA process does not reach, but I'm particularly interested in what we can do -- I mean, Burt and I

19 were talking about this before -- you flood a market with new dentists and it turns out you haven't improved

20 dental access at all for Medicaid beneficiaries because they're not seeing Medicaid beneficiaries.

21 So, this, I think, is our biggest challenge is where do we rely on evidence that's already been

22 produced and then move on from there versus original research.

23 CHAIR ROWLAND: You know, I think we all should remember that our statutory authority says

1 we need to look at shortage areas, which is why we're going to have the next session, as well. But clearly,
2 one issue is, are the Medicaid beneficiaries having limited access because they live in health care shortage
3 areas or is it because providers don't participate?

4 And one of the common assumptions has always been, oh, it's because no doctors will participate in
5 the Medicaid Program, yet I think it's our obligation to look at what really explains the access deficits and
6 the provider shortages and how they work.

7 COMMISSIONER HOYT: Sort of a related question, in my mind, would be, if we reset the
8 metrics, you feel like we have better metrics now on how to establish satisfactory access, if you put those
9 into contract requirements for an MCO and they contract in one of these areas, did it work?

10 Do the beneficiaries have the access now that that was supposed to, maybe not guarantee, but get
11 them there? Do we have some way now to measure that? It doesn't feel like we've moved closer in that
12 direction.

13 COMMISSIONER MOORE: Kind of along that line, in the chapter, the draft chapter, you
14 mentioned the California proposal for an access monitoring system and I guess it hasn't actually started, but
15 it's rather a -- and it sounded like it was the first -- I think you used the word "systematic" systems, which
16 made me think maybe you were referring to something that was somewhat different than other states have
17 done or than California has ever done before. I am just curious to know what we know about other state
18 programs for monitoring access or MCO programs for monitoring it.

19 MS. SIMON: I think California rolled out theirs at the beginning of the year, and so it's just
20 beginning, and how it's going and where they are and how they're tracking, it was to come up with annual
21 reports, but also monitor a bunch of indicators on a quarterly basis to be able to track, as they called them, I
22 think, "early warning indicators." So, if something were to happen in the immediate, to be able to tell.

23 We would need to look further on what kind of monitoring they're doing and what they're finding.

1 COMMISSIONER RILEY: Yes, I think to follow up on that, it would also be interesting to know
2 what administrative burden that system -- because we know the history of how California got there. What
3 is the administrative burden? What does it cost? Is it a replicable model? Do other people do other
4 kinds of things? I think would be really important, as well as to continually -- in this chapter, as we have
5 always said, my broken record, it's access to appropriate care, and just to keep focusing in and make sure
6 we're buying economic and efficient and appropriate care.
7 Parenthetically, we didn't get a chance this morning to talk about it: I know we can't comment on
8 all the rules, but it strikes me that there's an opportunity for us to really look at an access initiative around
9 the two-year bump in primary care payments, because as it -- I mean, pull-my-hair-out crazy, a two-year
10 bump. It invites gaming, it invites not paying a lot of attention, it invites worries about how does it
11 continue. So, I think it is really important that we watch this and see how it plays out, recognizing that it's
12 a contrivance to have a two-year bump, but to see what we learn from it.
13 There are those who assume that as soon as you increase payment, boom, you solve the access
14 problem overnight. There are others who say, unless this two-year bump is somehow understood to be a
15 demonstration, it really can't achieve much of anything, but I think it gives a real time, real moment
16 experience in access to really take a hard look.
17 And so, while we can't comment on the rules, maybe a letter to just sort of suggest that a two-year
18 bump is just that, but that we ought to really track this over time and see what happens.
19 COMMISSIONER ROSENBAUM: Would you draft that letter?
20 COMMISSIONER RILEY: Sure.
21 COMMISSIONER GABOW: But to Trish's point, if you do something for two years, you have to
22 add very real-time data, which we know we don't have. So, while I think it's important to know what's the
23 outcome, we might not know that for a very long time, if you look at it.

1 COMMISSIONER RILEY: It's true, but there will be people making conclusions based on it,
2 regardless of the data. So, it seems to me it's important for us to focus in on what evidence we have or
3 don't have.
4 COMMISSIONER ROSENBAUM: And if we do that, I think it is also important to do a careful
5 analysis. I mean, I realize it's in proposed format, but the rule as proposed is a very complex rule.
6 There's really only a small, relatively small, subset of people who will potentially benefit, and the actual
7 payment of the bump can be delayed by a long time because of the verification and documentation
8 requirements.
9 So, it's a strange bump in that there's a bump, it's short, and it's complex to administer. And so, we
10 may be able to draw many kinds of different inferences from it, including that, if you're going to do this, it
11 has to be a shot in the arm that's a lot faster.
12 CHAIR ROWLAND: The bump is short in the requirement from the Federal Government
13 matched with the 100 percent Federal funds.
14 I think one of the concerns there is that it may not be short in terms of how long the states do it,
15 and that's why I think evaluating how well it may be changing some of the things may be very helpful to
16 know whether continuing it is worth it or not.
17 Okay. Well, thank you, Lois. I think that we always like to look at our access issues and the data
18 and information that we can be using to evaluate access and we always recognize that there's no perfect data
19 world ever, but especially in the Medicaid world, it's never as perfect as we would want it, but you are
20 helping us to at least figure out where there are some better indicators. So, I thank you.
21 MS. SIMON: And if anyone has any comments on the chapter itself, just send them on to me, it
22 would be great. Thanks.
23 CHAIR ROWLAND: Thank you.

SUMMARY OF ACTIVITIES AND RECOMMENDATIONS OF THE HRSA NEGOTIATED RULEMAKING COMMITTEE ON MEDICALLY UNDERSERVED AREAS (MUAS) AND HEALTH PROFESSIONS SHORTAGE AREAS (HPSAS)

CHAIR ROWLAND: And I think we're actually, since we've already started to allude to shortage areas in the calculation, we want to welcome our guests from HRSA to the table and ask Lois to come back to the table and introduce them.

We're at Tab 5 and on "Summary of HRSA Negotiated Rulemaking Committee on Medically Underserved Areas and Health Profession Shortage Areas."

And so, I want to welcome Andy Jordan and Lynn Nonnemaker to our meeting and ask them to both introduce themselves in terms of their area of work. Their bios should be in our books, but can you start before your presentation by telling us a little bit about what you've been working on and what you bring to the table and then go into your presentation.

MS. JORDAN: Sure. I'm Andy Jordan. I am the Director of the Office of Shortage Designation. So, I have an intimate with some of the things you were just talking about. I've been there for 10 years. I've been in HRSA for almost 34 in various capacities with health centers, most of it -- more time with National Service Corps, and then working with designations. So, this is a subject that I've spent a lot of time working from a number of different angles.

Lynn, you want to...

DR. NONNEMAKER: And again, I'm Lynn Nonnemaker. I'm the Deputy Director in HRSA's National Center for Health Workforce Analysis, and so I can talk to you about some of the activities that the National Center has ongoing, aside from the negotiated rulemaking that Andy will talk about.

And I'm fairly new to the Center. My background is largely in Medicare and general workforce and physician and graduate medical education issues.

1 CHAIR ROWLAND: Great, thank you.

2 And I think you will all find their slides at Tab 5, again, at the end of the tab.

3 MS. JORDAN: First of all, let me say I'm honored to be here as a substitute for Ed Salsberg, who
4 was actually the invited speaker, and was a member of the Committee, the Rulemaking Committee.
5 Shortly after he joined HRSA, he got dumped into that opportunity, which I'm not sure he's ever recovered
6 from. I'm not sure any of us have ever recovered from it, actually. But he asked me to fill in, since a lot
7 of what you're really interested in was the Committee specifically, and Lynn's going to fill in with some of
8 the Center work that they've been doing. And clearly, we work together a lot because a lot of what we do
9 crosses lines.

10 It was a bit of a challenge to figure out exactly what to share with this Committee. There are some
11 of you who could probably give this presentation because of colleagues of yours. Great spending time
12 with your former colleague, Dr. Babitz, who was a member of the Committee and --

13 VICE CHAIR SUNDWALL: Did he do a good job?

14 MS. JORDAN: -- he was the most vocal proponent for health status overall. Other things come
15 after that. And every time, he would come back with that.
16 He was very successful, he was very good at that, and it was great to see him, too.

17 So, I tried to include some slides that give a little bit of background for people who don't know
18 anything about HPSAs and MUAs, which is fine. There are lots of reasons people shouldn't worry about
19 them.

20 So, the first couple of slides just give the basic rules, criteria for the HPSA designation process, and I
21 want to add, given the conversations that you all were having just after we got here that -- ah, okay. So, do
22 I push the button and then it will move? Technology is not always my friend.

23 So, this is the basic criteria, straight out of the regulations. What is not on here related to your

1 conversation was we do this both on a geographic area and a population basis. So, the point that was
2 made earlier about there may be lots of dentists or doctors there but they may not be taking care of the
3 people you're worrying about were having probably an increasing number of designations that are looking
4 either at the low-income population or actually, in some states, the Medicaid-eligible population. So, it
5 does, in some areas, take that into account explicitly, who is serving them and how much are they serving.
6 So, there is a way within this process to actually account for that particular issue if you're looking to use
7 some of this as a basis for some of your process. So, that's the basic rules. Obviously, for Health
8 Professional Shortage Areas, which comes from the National Service Corps legislation, the primary factor is
9 the population-provider ratio, and then it's adjusted somewhat for some other factors.
10 The next slide is the medically underserved area designation. These regulations, again, 30-plus
11 years old. It is a formula with four factors in it that are weighted depending on the values. Those are the
12 four factors that are used. So, not one of them controls the whole process. You can have different
13 combinations of them, and the results will be different depending on what those combinations are. And
14 then, there's the Governor's Exceptional, which is basically we don't meet the criteria but we have all these
15 other reasons we think you should be designating us, and there are a small number of those that are out
16 there.
17 But I didn't want to dwell a lot on this but I wanted for people, for reference, to have that
18 background information.
19 This is not a complete slide by any means, but this summarizes how they're used by the major
20 programs that we work with almost daily and which ones apply to which programs, again, just for reference.
21 Again, National Service Corps is the source of the HPSA designation and the Health Center
22 Program is the source of the authorization for the MUA/MUP.
23 As some of you are victims or participants in the wars we've been spending on this process since

1 1998, I was not involved at that time, directly in that update process. I kind of got involved towards the

2 end. There was a process available for methodology. It combined HPSAs and MUAs into one

3 designation process, the thought being a lot of people are confused about why are there two. A lot of the

4 data are the same, some of the processes are the same, but it ran into a firestorm of concern and complaints

5 so they started over again, had a lot of analysis done, produced another one in 2002, had a lot of

6 involvement by a lot of the stakeholders in that as well, came up with a very different approach, took into

7 account a lot more factors in terms of health status and other things, was basically finished in 2002, but

8 didn't get out as a rule in 2008, which caused problems for reasons other than our impact data were

9 somewhat out of date by then. A number of things had changed, but we didn't have the capacity to rerun

10 everything. And so, there were a lot of questions again about the results of that and so we took a step back

11 and were beginning to work on another revision when the health care reform legislation in 2010 required us

12 to use the negotiated rulemaking process to formally involve stakeholders in the process to get the support

13 and buy in and at least hopefully avoid the kind of reaction that happened in the past.

14 This is basically the charge of the Committee to look at some of the issues that you all are looking at:

15 timely availability, and appropriateness of data. Clearly an issue we spent a lot of time talking about.

16 One thing I didn't bring because it was not really complete, we had a couple pages of data sources

17 that were compiled at one point and suggested options to look at for -- maybe this will help us. Does it

18 cover the right area? Does it get to the right level geographically and those kinds of things?

19 The impact on various kinds of communities, particularly the existing safety net providers, health

20 centers, and others, rural health clinics. So, a lot of analysis was done on impacts and all those different

21 kinds of things, the difficulty for applicants to complete it, although a lot of that has been dealt with with

22 electronic application systems that we have now, but there's still an issue of how you count providers, and

23 there is no other way to do it very well other than actually surveying them, although Medicaid claims is

1 helping us with that piece a little bit.

2 And do we accurately measure barriers? Well, first you have to figure out what are those barriers
3 before you can figure out whether you can measure them.

4 The key questions that the Committee laid out at the very beginning that they wanted to address
5 based on the charge and the legislation, one being, should there be one or two? And they very quickly
6 decided there should be one, with not a lot of -- there should be two. Not a lot of disagreement about that
7 topic of reasons and discussion, but that was really the first decision.

8 Do they want to continue to have geographic and population approaches? How are they similar?
9 How are they different? Which providers to include? The debate about including nurse practitioners and
10 physician assistants, which we had included in the 2002 version. That is still a matter of debate and what is
11 going to be the impact of that on the whole thing and how do you adjust ratios to take that into account.

12 What do you do with providers at safety net facilities?

13 How do you estimate need and demand?

14 Questions, of course, that you all know the answers to, I'm sure.

15 What are the key barriers to access and how are they measured? And you are here discussing some
16 of those same questions.

17 What do you mean by "ability to pay"? That's a factor we have to look at. What does that mean?
18 How do you measure it? How do you account for that? And how do you combine that with all the other
19 things?

20 And again, as I mentioned, Dr. Babitz was a proponent of bad health status -- if you've got good
21 health status, you don't have those other things, who cares? Your health is fine, it doesn't matter. You
22 don't have any providers or whatever, maybe you're better off. So, there are lots of different opinions on
23 that.

1 How do you combine those different issues of ability to pay, health status, provider availability,
2 accessibility into some kind of process?
3 How do you define a rational service area? How big should it be? How small should it be?
4 How do you look at those factors?
5 And what is underservice? How bad is bad enough to be considered underserved? Just barely
6 below the perfection, whatever perfection is, or some degree below that, and those are things, needlessly to
7 say, we spent a lot of time.
8 I'm not going to go over these slides because obviously it would take forever, but one of the first
9 thing the Committee was basically plaster the wall with everything they could think of that were barriers to
10 access. So, let's throw it all out there and then we'll sort of work our way through this. So, there are four
11 or five pages here that they threw up there which you can have for reference and see if we left something
12 out, I don't know. But I was not going to read those slides to you.
13 But needless to say, four or five pages of stuff is a lot and you can't do a whole lot with that. You
14 have to sort of work your way through it and winnow it down to something a little more useful.
15 And of the conversations over 14 months -- the Committee met for 14 months. We met every
16 month except one, with a lot of conference calls in between, a couple of webinars for the whole Committee,
17 a lot of subcommittee work, and through that process they narrowed down that long list of things to these
18 factors that they wanted to include in the formulae, in the process, in the discussion, in various ways.
19 Health status, clearly, a number of different ways to look at that, lots of discussions about which ones to
20 pick and why. That's where they ended up in their deliberations primarily, although they did have some
21 options for local option, local factors in some of the models that -- you may not have any of those as these
22 problems, but maybe you've got one particularly that's different, and you can throw that in if you've got
23 good data.

1 The whole socioeconomic determinants, those are the other factors that they looked at a lot,
2 although they are not all in the formulae anymore, but those were working with people from the Graham
3 Center looking at some of their work in what are the factors that really are significantly related to health, and
4 maybe you can measure those if you can't measure some other things.
5 And ability to pay, those are the measures they come down to.
6 VICE CHAIR SUNDWALL: Andy?
7 MS. JORDAN: Yes?
8 VICE CHAIR SUNDWALL: I don't want to delay this, but I'm just curious, I've never seen on
9 the socioeconomic determinants a percentage of population with less than high school population.
10 MS. JORDAN: This came out of the Graham study that Bob Phillips was doing.
11 Oh, I'm sorry, education, you're right. Sorry about that. I copied these from --
12 VICE CHAIR SUNDWALL: Does that mean it is so rural and remote they don't have enough to
13 muster enough students for a high school?
14 MS. JORDAN: Or it's a particularly poor and unsuccessful urban population that people don't get
15 out of high school. You might have that in D.C.
16 VICE CHAIR SUNDWALL: Okay. Okay, that --
17 MS. JORDAN: Education, sorry about that.
18 VICE CHAIR SUNDWALL: Okay. Thank you, I was puzzled there. I wondered how much is
19 not enough to have a high school.
20 MS. JORDAN: Sorry about that.
21 So, anyway, that's kind of where we needed up going from five pages of questions and issues to,
22 these are the major factors that the Committee was looking at when they were getting towards organizing
23 their models.

1 This is the model that the Committee recommended in terms of the MUA. You can see the
2 choices they made for health status and how they were -- how they wanted to weight them, how they were
3 counting the providers up at the top; again, lots of discussions about how do you count OB/GYNs? Are
4 they or are they not primary care? We don't even agree on that in the Bureau of Health Professions. So,
5 that was an interesting discussion. And how do you count the PAs, nurse practitioners, and nurse
6 midwives, and those kinds of things.
7 The barriers of care, again, that whole laundry list narrowed down to some of those things that were
8 included on the list, and lots of discussions on how do you balance urban and rural and all of those things
9 and coming to those conclusions.
10 So, that's the model that they came up with for a basic medically underserved area. Same process
11 we have now: Factors into one formula produces a number at the end. I don't expect you to memorize
12 this?
13 Yeah?
14 COMMISSIONER ROSENBAUM: Question: The measure -- of course, one of the things
15 that's so remarkable about the MUA/HPSA designations is how many different programs are driven by
16 these designations.
17 So, I assume that it was your -- it was the consensus of the group that these were the factors,
18 regardless of whether the application was going to be to a remedy that would literally up the physical supply,
19 you know, you bring in a doctor, you bring in a National Health Service Corps doctor, you open a health
20 center and staff it, versus a remedy that would create better access to existing supply, like a payment increase
21 or whatever.
22 So, from your perspective, it didn't really matter whether you were physically trying to up your
23 supply or make better use of the supply that was there. These were the factors, these are the key factors.

1 MS. JORDAN: Right. We're still grounded in the legislative authority we have to address certain
2 kinds of things. And again, they tend to go back to the programs within which that legislative authority
3 lives. So, what CMS does with it for other purposes than anybody else does with it, we took that into
4 account in looking at impact, but in terms of how to design, that was really not a particular factor.
5 So, the MUA and MUP, again, are both related primarily to the Committee Health Center Program,
6 and so they have a combination of provider accessibility, barriers to care, health status.
7 And my answer to the question, why are there two, has always been, it's a system of care
8 intervention. So, it's a more complicated problem and needs a different kind of solution than just
9 dropping a doctor in it.
10 Whereas HPSA -- and I don't actually have a HPSA slide -- but the HPSA slide would be very much
11 like now: It is basically driven by provider population. What's different is that there is an adjustment
12 applied for the health status so that if health status and economic factors are worse, the ratio can be a little
13 bit different. So, it's a very complicated slide that would take a long time to explain. But again, it's driven
14 primarily by the ratio with some adjustments for these kinds of factors, exactly the same kinds of factors
15 that are used here, which is why I didn't produce the slide again, but a different result, because it's driven
16 primarily by the ratio.
17 There was an additional tweak added that there's a lower ratio for frontier than was used for the
18 overall population.
19 But since your focus is really on the access issues, I wanted to share most of these kinds of details in
20 terms of what the Committee came out with.
21 They came out with a couple of new things in terms of facility designations than had been done
22 before for areas that don't qualify for geographic or population but do seem to be serving the right kinds of
23 populations. How do you account for that?

1 So, a safety net population facility was actually one that was in the previous version, so they've kind
2 of repeated that one, that if you can show your users constitute a high-impact, high-need policy below 200
3 percent of poverty, uninsured, other things that becomes an underserved population in and of itself.
4 The magnet facility was a new one that was added that, if you're serving -- and this is particularly
5 relevant for the LGBT and some of the Asian and other minority communities where you may serve a very
6 large geographic area. It's not anything somebody would call a rational service area. It may be three
7 states in some cases. It may be four or five counties, but because of the nature of the services you're
8 providing and your expertise, you may be drawing from a much bigger area, and they came out with a
9 magnet facility option for that, which is a new thing, and the last one was an essential provider. If you're
10 the only person providing care in most of the area, is there a way to account for that?
11 So, those were a couple of new tweaks on issues of access and how to account for some special
12 conditions, if you will.
13 VICE CHAIR SUNDWALL: So, does this mean Denver Health is underserved, because the
14 whole City of Denver is now a HPSA because Denver Health is there?
15 MS. JORDAN: No, most of Denver is not a HPSA. There are some, but they --
16 VICE CHAIR SUNDWALL: Where did Patty go?
17 MS. JORDAN: There must be an MUA somewhere, because they're funded, and there certainly
18 are underserved areas within it, and they could possibly meet the safety net definition, if they have --
19 VICE CHAIR SUNDWALL: I was just thinking of the institutional --
20 MS. JORDAN: It's a fair question.
21 So, that's a rough overview of the Committee where we started and where we ended up, just to close
22 that loop.
23 The Committee produced a report in October. That information is all available on the Committee

1 website. If you really have trouble sleeping, you can pull it up and read it.

2 They did not reach consensus on all of the recommendations, so within the department there's an

3 options paper being considered and it's under review right now. So, we ended in October of last year.

4 So, that's that overview, and Lynn's going to talk a little bit about the National Center and what they're up

5 to.

6 DR. NONNEMAKER: Right.

7 So, obviously, underpinning all of the designation is the quality of data. And so, the Center has a

8 role to play in trying to improve data quality, the workforce, both on the supply and the demand side. And

9 so, I just wanted to take a minute to describe the efforts we have ongoing in that regard.

10 Now, the National Center, in our current configuration, has only been around for about 18 months

11 now. We were created as part of the ACA.

12 There was also a commission set up as part of the ACA, and the members of the commission were

13 appointed but funds have not been appropriated, so they're not able to function at this point, but we are --

14 CHAIR ROWLAND: This Commission had a little similar history, so we're sympathetic.

15 DR. NONNEMAKER: Okay, you can appreciate it.

16 But we have not let that stop us from going full steam ahead. So, our approach -- I think there are

17 three components to the approach the Center is taking to develop data. First is to strengthen really state

18 capacity for data collection and analysis, and also the capacity of professional associations, licensing boards,

19 certification boards, to collect consistent quality data on their workforce.

20 And to that end, an important activity is developing and promoting a national uniform minimum

21 dataset for health professions. So, we're trying to work with existing data sources, for example, the nursing

22 boards have an ongoing project to develop a minimum dataset for nursing. We've been working with

23 physicians, also dentists, dental hygienists, physical therapists, pharmacists, physician assistants, to try and

1 get a consistent data collection process and instrument in which everyone can agree on the very core
2 components that they need to collect so that we have a good count of the provider population.
3 And then, the last element is supporting research so that we have a better understanding of needs
4 and dynamics, and so we're doing some research on retirement and trying to understand activity status and
5 when we see people leave the workforce and enter and trying to work with states to get consistent collection
6 of things like what's an FTE, what is an active provider and things like that. So, we are both doing some
7 research in trying to support other research in these areas.
8 So, some of the activities we have ongoing, again, I mentioned the minimum dataset for the health
9 professions. We also have one specific to behavioral health. And we are really focusing on very core
10 components: Who is the person; what is their education; some of their demographics; what settings are
11 they providing care in; and then, what kinds of activities are they doing? Are they providing direct patient
12 care? How much of their time is in direct patient care, and so on?
13 And of course, many of the licensing and professional associations and state boards collect a lot
14 more information, and we support collecting additional information and really trying to build out our
15 datasets, but we're trying to, again, start with this very core set of data.
16 By the end of the year, we should have published projection models of supply and demand for
17 physicians across clinical specialties, and we're working on models for nursing and a number of other health
18 professions.
19 We, in the next year, hope to have projections for the oral health workforce, and some of these
20 projection models are pretty general, in which we try to develop a methodology that we can apply across a
21 number of different professions, and then we're also taking a much deeper dive and developing a more
22 detailed methodology for specific professions, taking into account the very specific characteristics of those
23 professions.

1 We are responsible for the Area Resource File that we're renaming the Area Health Resource File.
2 We're expanding and developing that. We're adding data at the state and also national levels to that and
3 also trying to build out the information we have at the county level. We know that's a really critical
4 resource for many people doing analysis of health care, health workforce, and so on.
5 And then, lastly, again, this analysis of factors driving supply, distribution, and demand.
6 And the one point I should make is one of the things you do not see on here, and it is important to
7 note, we do not do workforce planning at the National Center. We're trying to provide support and data
8 for others, particularly at the state level who do planning, but we do not do planning, and we do not set
9 policy or make specific recommendations about the numbers of providers we need. Again, we leave that
10 to others and make sure that we have good data to support those who do make those decisions.
11 So, that's it.
12 CHAIR ROWLAND: To what extent do you have data on rather different components of the
13 workforce participate in the Medicaid Program and to what extent they take patients from the Medicaid
14 Program?
15 DR. NONNEMAKER: Well, we don't have, at this point, any specific information about the
16 Medicaid population that wouldn't be available to you and all the other data sources that you've talked about
17 --
18 CHAIR ROWLAND: Earlier.
19 DR. NONNEMAKER: -- earlier.
20 So, that's not, for example, whether a provider takes Medicaid patients -- is not part of the minimum
21 dataset because it's not really at the appropriate time when we're trying to collect data on the minimum
22 dataset. They wouldn't necessarily know what kind of patients they serve, if they don't -- they can switch
23 jobs and so on. So, we don't have that specific information that we're collecting directly.

1 VICE CHAIR SUNDWALL: Well, you are to be commended. This is amazing. I know how
2 hard negotiated rulemaking is because I lived through one of those on setting lab prices for CMS; it was
3 painful. We used to call it a two-day dental appointment when we would go to those things.
4 [Laughter.]
5 VICE CHAIR SUNDWALL: I'm sorry. I didn't remember you were here, Burt. It was just
6 awful -- no, not that going to dentists is awful. Preventive services are important.
7 CHAIR ROWLAND: And dental services, oral health services, are very important.
8 VICE CHAIR SUNDWALL: I know, I put my foot in my mouth, didn't I, dentists?
9 Anyway, the point is I appreciate the work that's gone into this and I know from Dr. Babitz's report
10 that it was challenging but I think all very worthwhile. I really appreciate the consensus that there be one
11 methodology, not two, which never made a lot of sense, although I understand the history of it.
12 Question for you: I just got my own survey from the AMA on my status as a physician, and it was
13 really a good experience because I think they must do it every three years, five years, I don't know.
14 DR. NONNEMAKER: I think every three.
15 VICE CHAIR SUNDWALL: Three? Probably.
16 But for one thing, it was a simple, readable form I could fill out in three or four minutes. And I'm
17 not a member of the AMA so I know the reach of this -- I am a member of the Utah Medical Association,
18 maybe they use those data. But I could tell in my -- what percentage of my time is spent doing teaching or
19 administrative or clinical care, and is my contact information current. So, I thought that was a good
20 source.
21 My question, understanding now freshly what the AMA does to monitor the physician workforce
22 and what they're doing, do you use that data or do you replicate it? I'm a little worried, from what you're
23 saying is, are you doing things that states are doing anyway, because we also have the Utah Medical

1 Education Council, David Squire, whom I sure you know who -- we do a terrific job of monitoring dentists
2 and nursing and PAs and the whole range of providers, neurologists, neurosurgeons.

3 And so, I guess I'm asking, do you service a clearinghouse for what states are already doing,
4 recommending core standards that they should do? And do you incorporate that AMA data in your
5 database?

6 DR. NONNEMAKER: We work extensively with the AMA Master File and we communicate
7 with the AMA. They're -- as you say, they collect a great deal of data. Their goal, I think, is to reach the
8 population of physicians and not just their members.

9 VICE CHAIR SUNDWALL: That's true.

10 DR. NONNEMAKER: But the database is not perfect, and so we've been working on trying to
11 make some adjustments to it and our goal certainly is not to replicate the AMA Master File. We are
12 certainly aware of it and, again, work with it on a daily basis.

13 And in terms of working with states and serving as a clearinghouse, again, we are working with them
14 that we see that as one very important piece of our mandate, and our goal is in fact to be a clearinghouse so
15 that as they improve their data collection efforts, hopefully it's not a requirement when we work with them,
16 but hopefully they can share the data with us so that we can then make it available to people doing research
17 and doing planning, but we're trying to take the efforts that they have ongoing and provide support and try
18 and get them to work with other states to be consistent so that we have comparable data across states and
19 then, again, to be the clearinghouse.

20 COMMISSIONER ROGERS: I just wanted to know that, with all this data that you're gathering
21 and what other divisions of HRSA are looking at this data as we look at the changes in the HPSA areas and
22 we know that we need to increase the workforce, health care provider workforce, in those areas, are you all
23 communicating with each other from the different divisions so that they understand the need for more

1 funding in order to increase those numbers and take care of the Medicaid patients?

2 DR. NONNEMAKER: Absolutely.

3 So, we're working with, for example, the Bureau of Primary Care, Primary Health Care, and clinician
4 recruitment services to work with what data do we have that they can use to inform their programs as we --
5 again, we're still in the early stages of trying to actually gather data from states and so on, but as we get more
6 data, we will certainly be sharing it with other divisions of HRSA.

7 CHAIR ROWLAND: Okay, Denise.

8 COMMISSIONER HENNING: I actually have two questions. One is for you and one is for
9 you. My first question is, since you're saying that you don't have -- you can't really correlate the providers
10 with who is actually serving the Medicaid population, why is it that you're not using -- or are you using the
11 National Provider Identifiers in order to, you know, make those connections?

12 DR. NONNEMAKER: Right. So we are working with the NPI data, just as many others are.
13 So, you know, I wouldn't say that that is information that we have that's proprietary, but we are certainly
14 working with the NPI file trying to understand the quality of those data, how we match them, for example,
15 to the AMA master file so we get a really good accounting of who's in practice, who's active, what kinds of
16 care they're providing.

17 So we're certainly using the NPI and we recognize it as a really terrific potential source of data.
18 But, you know, it was not created for the purpose of doing research and so, I think we and others are still
19 trying to figure out how we can use it, you know, most effectively, productively.

20 COMMISSIONER HENNING: Okay. And then for Ms. Jordan, when I was a service director
21 of a nurse midwifery service at a Federally-qualified health center, one of the recruiting tools that we used
22 was the National Health Service Corps loans to get graduates out of school to come to our health center.

23 And one of the barriers that we had was the very restrictive hour requirements, and in particular, you

1 could only do 12 hours in a 24-hour period, when, especially, I would think, that it would be even worse in
2 an area that was really rural, because you may only have two or three providers that are covering 24-7.
3 So they're going to need to be on call for a really long time. And in my case, you know, I needed to
4 have a midwife on call for 24 hours in order to make things work. And it didn't fit with the rules under
5 that program. So it made it really difficult for me to staff my service with these scholars.
6 Do you have any idea why that rule was so restrictive as far as the hours? And if anything could be
7 done to change it?
8 MS. JORDAN: Do you want to comment on that question before I --
9 COMMISSIONER ROGERS: You know, that advisory council or that council has been taken
10 over by Rebecca Spitzgo, and there's many, many changes that have been made. I can't give you the
11 specifics in terms of the internships, but I'm on their advisory board and we have made lots of changes.
12 So I know if you go on their website, you will see the number of changes that have been made. I
13 don't know why that rule was because I wasn't there when that rule was, but I know that Becky has made --
14 the director has made many, many changes.
15 COMMISSIONER HENNING: Okay, good.
16 MS. JORDAN: Yeah. I was actually there just after some of those rules were put in. I mean,
17 one of the particular ones in terms of no more than 12 hours in at least four days, back in that time we
18 actually had people do emergency medicine in the national service but that's since stopped. But people
19 were working basically, you know, a weekend and then going off and doing something else. That's not the
20 intention of the program.
21 COMMISSIONER HENNING: Right.
22 MS. JORDAN: And those restrictions were put in to avoid that problem. Now, they may cause
23 another problem and I think a legitimate case can be made and I think they are -- the office that deals with

1 those issues is listening to some of those comments, and I think a presentation about the practice style and
2 the model and the requirements, I think, would get a hearing.
3 But they were put in for a reason. It's like many things. Things get abused and they put rules in
4 place and it causes another problem and you go back and forth. But I think an articulate, comprehensive
5 discussion about the model will occur, and I know those things have come up.
6 Now, I haven't heard that one, but I've heard issues about the models of care and the time and the
7 hours in other cases. They're doing a lot more part-time things now than they did before. They have
8 authority to do what we didn't have before, and some other things.
9 Particularly the mental health one has been real challenging in looking at that, but I think it's fair to
10 say that presenting that idea and that concern, you know, can get a hearing. And in particular, we've got
11 someone who's on the council is a really good way to do it.
12 And let me just add to the comment about the NPI. In all the work we were doing with the
13 committee, we were taking the MA data and the NPI, merging them, enhancing -- they basically sort of
14 enhance each other. Many times the addresses in NPI are better than the MA addresses. Where's the
15 actual practice address and those kind of things, it still doesn't get to the level of granularity that we need in
16 terms of how many hours were you actually there working and those kind of things, but it definitely has
17 been a tool and we will be continuing, when we load our system, that basically is used by the states for the
18 designations and we will be having the AMA enhanced by the NPI on that one probably if we do use it.
19 CHAIR ROWLAND: Mark, I have Herman, Sara, and Burt.
20 COMMISSIONER HOYT: I was wondering if you have the ability to do any kind of splits by age
21 or gender, like looking at women in the age of fertility, however you define that, 15 to 40 or 45, and ratios,
22 that population to OB-GYNs and nurse midwives or something like that?
23 MS. JORDAN: The current criteria do not cover that option, and it probably did come up in the

1 committee deliberations, but not a lot in terms of when you get to very age specific or sort of service
2 specific needs like that. I certainly hear it all the time from the community. You know, we have lots of
3 doctors, we don't have any OB-GYNs. We don't have any nurse midwives, so they're not meeting our
4 needs for that. But currently no, we don't do that.
5 COMMISSIONER HOYT: Sort of a related question, too. I'm channeling Burt now. If you
6 looked at kids, however you define that --
7 CHAIR ROWLAND: He has lots of surrogates on this Commission.
8 COMMISSIONER HOYT: -- under 19 or under 21, no ability to ratio that to dentists or oral
9 health providers?
10 MS. JORDAN: No, we've never done the age specific splits like that. I should mention that
11 HPSAs, by the way, are also done for dental and mental health. MUAs are just primary care, but HPSAs
12 are done for all three disciplines.
13 CHAIR ROWLAND: Herman?
14 COMMISSIONER GRAY: I'm a pediatrician and a lead at Children's Hospital, so we, of course,
15 are really interested in workforce pediatric subspecialists, surgical specialists. As an example, I think, you
16 know, there may be 20 or 30 pediatric neurosurgeons that finish the training every year. Are these data
17 sets going to be granular enough to see these kind of really small specialty groups?
18 DR. NONNEMAKER: I think the answer is it depends. So for some specialty groups, we will,
19 for example, in our projections coming out for physicians, we will be looking at projections by specialty, but
20 some specialties, the reality is that, you know, the numbers are just too small to get really good estimates.
21 And so, they wouldn't necessarily cover all specialties.
22 And we recognize that, for example, pediatric subspecialties can be particularly difficult. You have
23 small numbers and it can also be difficult to get measures of demand for some of the very particular

1 subspecialties.

2 COMMISSIONER GRAY: So what do you do with them? Do you lump them all together?

3 DR. NONNEMAKER: Well, I can't actually say what we plan to do for those that we decide are

4 too small. I'm not sure what our strategy will be at this point.

5 COMMISSIONER GRAY: Hopefully it's not to ignore them.

6 DR. NONNEMAKER: Hopefully not.

7 CHAIR ROWLAND: Okay. Sara and then Burt, the real Burt.

8 COMMISSIONER ROSENBAUM: My question is, where does all this sit today? So the

9 negotiated rulemaking process concluded. Where does the results of the negotiated rulemaking process sit

10 in terms of formal policy? I'd really love to hear your perspective. Given the recommendations of the

11 rulemaking process, what do you see as the most significant changes that might result from this amount of

12 work in terms of how we've thought about MUA, HPSAs, where the negotiations sort of ended up. And if

13 the Department, the Administration sort of goes with the flow of the recommendations, what would be the

14 big shifts?

15 MS. JORDAN: I mean, what I said before is the answer to the question. The committee

16 completed their work, submitted their report. The report and an options paper developed by HRSA is

17 under review in the Department. That's where it sits. The other question, again, that's difficult to

18 answer.

19 I think the one thing, not unlike the last time that there was no disagreement about, really is making

20 sure we include the entire primary care workforce. That's not a new idea and it was reinforced again that

21 that's a growing segment of the provider workforce and nurse practitioners and nurse midwives, and you

22 can't ignore them when you do something like this. I think that's a clear outcome, if we ever get there.

23 Beyond that, I'm not sure there's a clear answer or direction from the rest of the deliberations.

1 VICE CHAIR SUNDWALL: So is the comment period closed?

2 MS. JORDAN: There is no comment period. Nothing was --

3 CHAIR ROWLAND: It's just a report.

4 VICE CHAIR SUNDWALL: I'm sorry.

5 MS. JORDAN: What will come out will be an interim final rule. There will be comment after
6 that, but it will come out as an interim final rule when it comes out.

7 CHAIR ROWLAND: Okay, Burt.

8 COMMISSIONER EDELSTEIN: My question is for Lynn in the context of the National
9 Workforce Center, and that is that HRSA is committed to the care of the under-served. Medicaid is pretty
10 well a proxy for the under-served. And so, I'm wondering if the Center is looking at all at the Insured Kids
11 Now website and assessing the validity of the reported providers for Medicaid enrollees there?

12 It's of particular interest because GAO has looked at it and found it to be wanting and it does have
13 significant problems.

14 DR. NONNEMAKER: I can't say that we've looked specifically at that website, but certainly I'll
15 take that back and we'll take a look at it. And if you have additional suggestions, we're happy to hear.

16 COMMISSIONER EDELSTEIN: Yeah. The additional suggestion would be to make it work.
17 It's profoundly flawed and it is touted as the resource for Medicaid beneficiaries to find providers. And so,
18 the idea, the concept is good. Congress was very excited about it, but it didn't turn into something that's
19 particularly useful.

20 So I've wondered where in the Federal structure there's a home for really looking at it analytically
21 and determining why it doesn't work well and then what can be done about it. There's clearly a crossover
22 with CMS because much of it is predicated on claims submissions.

23 But it strikes me that with HRSA's commitment to the under-served and this Commission's concern

1 for those in Medicaid, there's a reason for your center to take a look at this as well.

2 CHAIR ROWLAND: Burt, the database is currently put together by CMS?

3 COMMISSIONER EDELSTEIN: To my understanding, yes. The states, each of the states is

4 required to put it together under CMS guidance.

5 MS. JORDAN: I can tell you that we spent a lot of time with CMS trying to get the Medicaid data

6 so we can do projections and estimates using the models for that population. And, you know, when the

7 first couple of runs we got were missing like King County, New York, and Miami Dade, and there were

8 huge holes, which obviously caused us enormous concern, and it's a state program and the balance between

9 trying to get national information from states is real tough.

10 We're getting pieces and pieces of it, but I can imagine that that system has a lot of holes in it based

11 on what we've seen. We're still trying to get what we can get, but it's very difficult to get that data

12 comprehensively.

13 CHAIR ROWLAND: Well, you're reinforcing what we already know is that the data on this

14 program is very hard to get.

15 MS. JORDAN: There's no news in most of this, right?

16 CHAIR ROWLAND: We had really hoped that the Commission on the Workforce would have

17 been funded so that some of these knotty issues about the workforce and its interaction with the

18 low-income population could have been handled by a complementary commission and not ended up as

19 things that we need to struggle with along with all the other things that Congress gave us to look at.

20 What I wanted to really appreciate was, thank you for all these slides on the various barriers to

21 primary care that lead to under-service, because it is often thought of that there's just one or two things, and

22 I think just sharing with us the fact that your working group came up with so many barriers has really

23 instructed our efforts.

1 And obviously, as we try to struggle with the issues about how to evaluate access to care for the
2 low-income population, we appreciate your being here today, your sharing the work that you're doing with
3 us, and look forward to continuing to work with you as we all try and improve the way we can measure
4 access to care, the way we can look at physician and other provider shortages so that we can really make
5 sure that the low-income population that we're charged with and the general population is getting the right
6 mix of services and providers. So thank you for being with us.
7 DR. NONNEMAKER: You are welcome.
8 CHAIR ROWLAND: And now rather than take a break, I think that we would like to hear from
9 Chris who always presents to us some great data and we'll review our chapter on access to care for the
10 non-elderly adults. The real Burt wants to comment.
11 I think we're turning, Chris, are we not, to Session 6, Tab 6 of your briefing book?
12 **### CHAPTER REVIEW: ACCESS TO CARE FOR NON-ELDERLY ADULTS**
13 MR. PETERSON: That's correct.
14 Thank you, Diane. The purpose of this session is to describe some of the changes we've made in
15 this latest version of the chapter on access to care for non-elderly adults enrolled in Medicaid. And we
16 seek any additional feedback and guidance you have on the proposed chapter.
17 Once again --
18 CHAIR ROWLAND: I want you to account for all those barriers that they just laid out.
19 MR. PETERSON: Yeah. We've got a few.
20 VICE CHAIR SUNDWALL: Have them memorized.
21 MR. PETERSON: Once again, your materials are in Tab 6. They begin with the introductory
22 materials for this session. Following that is the draft chapter. And after that is the contractor report and
23 technical appendix. Just like for the March chapter on children, the contractor report and technical

1 appendix will be available online with more detailed findings and technical descriptions of the methodology
2 used.
3 Here on this slide is the current proposed outline for the chapter. One of the structural changes
4 we made was to add the second to last section on comparisons of Medicaid enrollees with and without SSI.
5 In this latest draft chapter, we note that we had to use three years of data to produce these particular results
6 in order to obtain adequate sample size for this analysis. So we would appreciate your feedback on this
7 potential new section.
8 Based on your feedback in the last meeting, we made numerous changes to this chapter, which we've
9 tried to categorize here, and not that this captures everything. First you said you wanted descriptions of
10 past research from the peer reviewed literature besides just the citations that were there before. We now
11 describe four articles spanning from 1996 to last year using national survey data that analyze adults on
12 Medicaid and comparing them to adults on private insurance and/or the uninsured while controlling for
13 individual characteristics.
14 You also raised concerns on particular variables. For example, what are the best variables to use
15 for highlighting unadjusted differences in the populations of adults enrolled in Medicaid versus ESI and the
16 uninsured.
17 So in the first part of the draft that describes some of the unadjusted descriptive statistics, which
18 illustrates how Medicaid enrolled adults differ from the uninsured and those enrolled in ESI, Figures 1 and 2
19 now highlight some different population characteristics such as the percentage reporting being in fair or
20 poor health and the percentage below the Federal poverty level.
21 You also asked about the findings on utilization of nurse practitioners, physician assistants, and
22 nurse midwives, and respondents' ability to accurately report that information. In response, we have
23 removed those findings from the chapter and instead report on whether individuals had an inpatient stay in

1 the past 12 months.

2 There was also a lot of discussion regarding the variable on whether individuals visited a specialist
3 during the year, and the folks from HRSA alluded to this issue as well. You raised questions about
4 whether OB-GYNs were included as specialists in the numbers and whether they should be included. And
5 HRSA's solution was to count them as .25s, so that was interesting.

6 But given how many women use their OB-GYNs as their primary care provider, they were included
7 as specialists in the prior draft. We had Dr. Long do additional analyses and produce results for the
8 specialists with and without OB-GYNs and for OB-GYNs in particular. The draft you now have takes out
9 OB-GYNs. The overall story is still the same, that adults without Medicaid were as likely as similarly
10 situated adults with ESI to have had a specialist visit during the year, and more likely than the uninsured.

11 However, not surprisingly, the levels were different as a result of taking out the OB-GYNs.
12 Previously we had shown, including OB-GYNs, that 50.4 percent of Medicaid enrollees had a specialist visit
13 during the year. Now by taking OB-GYNs out, 25.4 percent of Medicaid enrollees had a specialist visit
14 during the year. And there are now additional descriptions of this in the chapter, as well as in the
15 contractor report, and in particular, in Table 6 of the technical appendix.

16 There was also discussion on findings for specialty care based on the perspectives of providers. Of
17 course, our chapter is based on responses from surveyed households. But in this draft, we make additional
18 emphasis that looking at specialty care from different sources of data, from different perspectives such as
19 from the perspective of providers, can yield different results.

20 As an example, we included GAO's recent work on access to specialists through Medicaid, which
21 found that more than three times as many physicians reported difficulty referring Medicaid CHIP children
22 to specialty care compared to privately insured children.

23 Finally, you expressed a desire for additional discussion in the chapter on the impact of various

1 regression controls. We include a couple examples in the chapter to walk through what the unadjusted
2 differences show and then the impact of the two sets of controls, which were one for health status, and two
3 for demographic and socioeconomic characteristics.
4 We have tried to make clear up front, although I acknowledge it still merits some additional work
5 actually, the multitude of variables that we control for, that each of them could be the subject of their own
6 analysis of certain subpopulations of Medicaid enrollees and that this may be the type of analyses we do in
7 the future.
8 There were numerous other changes we made that I've not gone through. We think these changes
9 in response to your feedback have made the chapter better and we look forward to your discussion. Thank
10 you.
11 CHAIR ROWLAND: Thank you, Chris. Burt?
12 COMMISSIONER EDELSTEIN: I just wanted to congratulate the staff on this chapter and to
13 thank Lu and staff for giving me a call to discuss concerns that I have about the methodology used in this
14 chapter, same as in the pediatric ambulatory health service chapter as well. And I want to clarify for my
15 fellow Commissioners what my concern was and what the staff's response has been.
16 The critical thing, I think, for us as a Commission is to not in any way mask the nature of the
17 population that we're attending to. And I very much understand and value the technique of regression
18 analysis to pull out and identify the impact of a particular variable, in this case the role of Medicaid in
19 addressing the needs of the population.
20 What I've suggested, and I think it will be good to generalize this as a guiding principle for all of our
21 work, whenever we seek to do analyses that identify the subset of variables that explain differences and we
22 want to know the impact of Medicaid, per se, that we do that using regression analysis, as is done here, but
23 we first as a predicate explain that the Medicaid population is different.

1 And so, my suggestion is to first bump up, provide a deeper description, a more thorough
2 description of the descriptive statistics that distinguish the Medicaid population from the insured population
3 from the uninsured population for each of the variables of interest. Then do the regression to show what
4 the impact is of Medicaid and then come back at the end of the chapter to summarize the finding for the
5 Medicaid population in light of what was found under the regression.
6 I know that what I just said made sense to me, but I'm not so sure it made sense to others, especially
7 this late in the day, so let me recap. What I'm suggesting is that, for example, when looking at having a
8 usual source of care, having had a visit to a general doctor in the past year, having had a specialist visit in the
9 past year, having delayed medical care in the past year, that we first show the overall statistic for the
10 Medicaid population alongside the ESI population alongside the uninsured population.
11 So that you see what the overall number is, what the relative use of services are for each of those,
12 for the three populations.
13 CHAIR ROWLAND: The, quote, unadjusted number.
14 COMMISSIONER EDELSTEIN: The unadjusted. The descriptive statistic, the top level of
15 statistic. Then do the regression analysis to control for those -- now we know a few things that we can
16 control for -- trying to tease out the impact of having Medicaid coverage, thereby showing the value of
17 Medicaid coverage.
18 And then go back at the end to put the Medicaid population back in context from what was learned
19 in the regression. So yes, being in Medicaid does markedly improve your usual source of care over being
20 uninsured, and yet, the Medicaid population itself is so substantively large and has so much lacking of usual
21 source of care that even though we're better off in Medicaid than uninsured, we still have a very significant
22 quantifiable problem in Medicaid, per se. Was I closer?
23 CHAIR ROWLAND: I think that what you're really asking for is a set-up that's two dimensional

1 instead of one dimensional. I think the first dimension is to compare the actual characteristics of the
2 Medicaid population with the ESI population and with the uninsured, so that you can see the age
3 differences, the educational differences, the health status differences as reported by fair or poor health or
4 whatever, because what we do know, especially under the current rules, that an adult who gets onto
5 Medicaid is very different than some of the adults that are in the uninsured population and are poor, but
6 especially then the adults that are in the ESI population.
7 And then from that, look at the unadjusted rates of usual source of care, all the key variables, and
8 then say, But this is not a fair comparison because we haven't adjusted for the fact that the Medicaid
9 population is different. If they were the same or similar, because we'll never make them the same as the
10 ESI population or the uninsured population, in the characteristics we can control for, what is the effect of
11 insurance.
12 COMMISSIONER EDELSTEIN: And the value of doing it in two stages is that you don't lose
13 the characteristics of the Medicaid population itself. You don't pretend or leave the reader who's not
14 familiar with regression analysis thinking that you really have a similar population. You have a distinctly
15 different population. You want to be able to say so, but then you want to be able to explain, in as
16 analytical way as possible, the impact of having Medicaid coverage, which is very positive.
17 So yes, Diane, you said it far better than I. Two stages, one descriptive, unadjusted, followed by
18 the adjusted, and then put the two together so that the reader understands that yes, you're better off in
19 Medicaid, but still the nature of that Medicaid population leads you to having this very significant issue
20 around each of these variables that is described.
21 CHAIR ROWLAND: I think it also will allow you to show that even if you have ESI, the
22 utilization world is not perfect either. So that you can therefore see that it isn't that every -- 100 percent of
23 the people with ESI have a usual source of care and the Medicaid population falls shorter. In fact, in some

1 of those statistics, Medicaid actually comes out better than ESI.

2 COMMISSIONER EDELSTEIN: What I didn't want to lose was, for the Commission, was the

3 descriptor of the population we're concerned about, and sort of leave some readers not understanding that

4 we haven't masked anything through the regression, but we've made it more specific and more analytic. I

5 still want to know what the population itself looks like.

6 COMMISSIONER CHECKETT: It's a rare day when I will speak on statistics.

7 [Laughter.]

8 COMMISSIONER CHECKETT: That said, I really appreciate the discussion, Burt and Diane,

9 that you're providing to help me understand how we can best frame this, as someone who really -- this is

10 not my world. But what I've been concerned about is every time I read the phrase --

11 CHAIR ROWLAND: "Similarly situated."

12 COMMISSIONER CHECKETT: What?

13 CHAIR ROWLAND: "Similarly situated."

14 COMMISSIONER CHECKETT: Actually, there's a phrase in there about how we're going to

15 adjust for health conditions, and what concerns me is with so much of Medicaid, isn't that the point, that

16 they have these health conditions? And that's why lots of the most expensive ones are on Medicaid in

17 addition to poverty and other issues. And so I've been really concerned that we've been very statistically

18 accurate but not telling the full story, and so just an observation that I feel much comforted by this

19 discussion. I do think we absolutely cannot lose sight of the fact that the challenges that so many of our

20 Medicaid populations face is the mere function of the severity of their health condition and how hard it is to

21 find someone who can treat that, especially at a Medicaid rate.

22 So I didn't actually talk about statistics, just for the record there.

23 COMMISSIONER RILEY: Well, I want to talk about regression coefficients, see if I remember

1 college. I think this is absolutely right. The worry I have, though, is implicit in the law, which may be a
2 mistake in the law, but implicit is the need to compare access between Medicaid and ESI. So that's where I
3 worry a little bit because you ended with we still have a problem. Then I think we need to do a better job
4 explaining what the problem is because I think -- I got lost in this. I think it does need this kind of rewrite.
5 And my simple brain tried to bring it to the lowest common denominator. I think it says if, A, Medicaid
6 people are disproportionately sick, if you're a sick Medicaid person and a sick person with ESI, you have
7 virtually the same access. I think that's what it says.

8 It needs to say that -- because that's a very important finding, and I think it needs -- where Burt
9 goes, we still have a problem, and then you explain. But, you know, with those comparabilities, and then I
10 think do a better plain-language explanation about regression analysis, because I think our audience is our
11 policy people who won't get this, and it looks a little bit like -- whenever you do a regression, it looks a little
12 bit like you've got a conclusion that you want to prove. And I think we've got to painfully careful -- that's
13 not the case here -- that what we wanted to do, given the law that requires us to compare Medicaid and ESI,
14 was to be able to make an apples-to-apples comparison of people.

15 CHAIR ROWLAND: Yes, well, what I think is important here is that we're not looking at the
16 amount of care that someone on Medicaid gets. This is not their utilization. This is if you're on Medicaid
17 or if you have ESI, what's your comparative advantage or disadvantage in accessing the health care system,
18 and if you're uninsured. So it's the effect -- is the effect of having Medicaid different than the effect of
19 having ESI or different than the effect of being uninsured? You're measuring at that level. You're not
20 measuring the quality of access for people on Medicaid. That's a whole different report. But you're right
21 -- your interpretation is exactly correct.

22 COMMISSIONER RILEY: By definition, two different kinds of people.

23 EXECUTIVE DIRECTOR ZAWISTOWICH: What we tried to do was to control for those

1 people characteristics so that you were comparison comparable individuals.

2 COMMISSIONER RILEY: Right.

3 CHAIR ROWLAND: And that's why when Chris says he in this analysis only uses people who

4 had full-year Medicaid and full-year ESI, it's because otherwise you can't control for where insurance played

5 in the middle.

6 COMMISSIONER RILEY: Right.

7 VICE CHAIR SUNDWALL: You guys are to be commended on your being so analytical about

8 this because I can tell you as a primary care provider, having Medicaid helps a lot. I cannot tell you the

9 difference between the uninsured and the Medicaid in my primary care clinic when, if I need to make a

10 referral, I can't always find a specialist -- mind you, not all specialists, especially dentists. But I can always

11 find a specialist that will see a Medicaid patient. And so I don't want to underplay the benefit of having

12 Medicaid coverage. It's a blessing. I've said this so many times before the state legislature, who would

13 always take me to task on coming back for more money for Medicaid, I'd say, "It is a blessing in the lives of

14 those who have it and who need it, and don't you have a neighbor or family member or someone." And

15 so I don't want to underplay the benefit of having Medicaid coverage.

16 But the last point I want to make is, Diane, you said something that has been troubling me because I

17 wondered if in Chris' analysis we weren't addressing what the commonly held public perception is, people

18 on Medicaid abuse it and overutilize it. And there's plenty of that. But I think if we maybe also up front,

19 in addition addressing this population comparison, to say this is not a utilization report, it's an access report.

20 So I think people kind of -- I think it's kind of a subtle difference, really, but we need to make clear we're

21 not talking about utilization, because I think there are examples of overutilization of Medicaid patients.

22 But that's not what this report is on.

23 CHAIR ROWLAND: Although it does do utilization. I mean, some of the measures are

1 utilization.

2 EXECUTIVE DIRECTOR ZAWISTOWICH: But it's self-reported utilization.

3 VICE CHAIR SUNDWALL: But we don't get it -- there's no way here to address overutilization.

4 CHAIR ROWLAND: No, because it's self-reported utilization.

5 VICE CHAIR SUNDWALL: Okay.

6 CHAIR ROWLAND: And comparative.

7 Other comments?

8 COMMISSIONER EDELSTEIN: Yes, I don't want us to understate the value of having

9 Medicaid either. I just also don't want to understate the difference between the Medicaid population and

10 the ESI population and the uninsured population. And if we use as a setup the comparison of the three

11 populations and then do the regression and then put it back together again at the end, then we get the best

12 of both.

13 CHAIR ROWLAND: Okay. Other comments?

14 COMMISSIONER COHEN: I do just want to follow up on Trish's point, and I can't remember

15 how much this is in the draft, but I do think it's important to note that it's because the law requires this

16 comparison that we're doing this comparison, because Medicaid is probably a needier population on the

17 whole. And it may be that Medicaid's standards should be higher, you know, but -- I mean, really. So --

18 and the federal government's purchasing power to make sure that its programs and state programs are even

19 more effective than what the commercial market could provide.

20 So, anyway, my point here is only we should be clear why we're doing this comparison.

21 CHAIR ROWLAND: I think it also goes back to a point we've made before. There's no

22 standard for what is the right level of care for any population.

23 COMMISSIONER COHEN: Exactly, yes.

1 CHAIR ROWLAND: So the only way we get at is Medicaid comparatively doing as well as private
2 insurance or not is a standard because there's no -- you have to have X number of visits. I mean, in a few
3 issues in pediatric care, there are actually standards for how often you get different visits. But they're
4 mostly lacking totally for adults.
5 COMMISSIONER EDELSTEIN: And some of the ones we have are bogus.
6 COMMISSIONER COHEN: And ESI access today is probably a lot different than it was 20 years
7 ago when co-pays weren't so high and deductibles weren't so high. So, I mean, I just think we should be
8 clear that it's not necessarily the gold standard. It's a standard.
9 COMMISSIONER EDELSTEIN: Yes.
10 CHAIR ROWLAND: Okay. Other comments?
11 [No response.]
12 CHAIR ROWLAND: Great. Thank you, Chris.
13 **### REVIEW OF MACSTATS, JUNE 2012**
14 CHAIR ROWLAND: And now we always have a nice conclusion with April and more data
15 numbers, information. MACStats.
16 MS. GRADY: Yes, we've got incredible stamina today, getting the short end of the stick here, but
17 I hope you can bear with me.
18 I wonder if Matt could help with the slides here. They don't seem to be popping up. Oh, here
19 we go.
20 Okay. In our April meeting, I provided a broad overview of the June MACStats that we had
21 planned, including a description of the data sources in that presentation. And today I'm going to provide a
22 brief update and point out some of the key findings in each section, which is something, again, that we're
23 going to focus on in the write-up that we have in the report itself. And as a reminder, you can find copies

1 of all of the draft tables and figures that we provided in Tab 7 if you want to follow along in your meeting
2 materials.
3 As a reminder, we have five sections in the June MACStats. The first is on trends in Medicaid
4 enrollment and spending. Section 2 looks at health and other characteristics of Medicaid/CHIP
5 populations. Section 3 is on Medicaid enrollment and benefit spending. Then we move to Medicaid
6 managed care. And the final section is a technical guide to the June 2012 MACStats with all of the gory
7 details for the data nerds out there who want those. There's a reason it's Section 5, last.
8 Here what you'll see up on the screen is basically a table of contents, and I'll sort of orally walk
9 through some of the key findings, and maybe pause to see if you have any particular questions on sections
10 as we go along. Obviously, we'll have time at the end for questions also.
11 Section 1 provides information to show that the growth in Medicaid spending and enrollment has
12 varied over the years and that the contribution of various eligibility group to spending growth differs. So
13 you'll see in Figure 1 that enrollment and spending track each other pretty well over the long period of
14 Medicaid's history from 1966 forward. But there are some periods in time, for example, the early 1990s,
15 where, say, spending shot up while Medicaid enrollment was relatively flat, and then other points in time
16 where enrollment is growing pretty steeply but spending is not growing as steeply because of increases in
17 relatively low-cost populations during recessions, like non-disabled adults and children. So we have a
18 discussion of that general issue in Section 1.
19 You'll also see in Table 2 -- this is something that we've talked about a lot over the past year, and
20 particularly in the March report, and that's that more than half of the growth in real Medicaid benefit
21 spending since fiscal year 1975 is attributable to individuals who are eligible for Medicaid on the basis of a
22 disability. So though these folks are a relatively small share of enrollment, they account for a very large
23 share of spending growth over the years.

1 One thing we do point out in the text accompanying the MACStats is that this Table 2 look at
2 Medicaid spending growth in the eligibility groups that are responsible growth takes a long view of the
3 program over several decades, since 1975, and we would point out, however, that this sort of analysis can be
4 used to examine growth over a shorter period of time, for example, the recent recessions where you would
5 find some different results, perhaps that non-disabled adults and children are where the spending growth is
6 during that short period of time simply because of reduced incomes and job losses during that period. So
7 there is some variation, but we sort of take a long view in MACStats in particular.
8 Before I move on, any questions on Section 1?
9 [No response.]
10 MS. GRADY: Okay. Section 2 is where we look at the characteristics of Medicaid and CHIP
11 populations. You've actually gotten probably a lot of this if you've reviewed the access chapters that Chris
12 Peterson has presented because a lot of the regression analyses control for these characteristics that we
13 present in the tables here. They provide a lot of useful detail in describing how Medicaid and CHIP
14 enrollees differ from those with other types of coverage, and, again, that's something that you just had a
15 discussion of.
16 For example, Table 3.B shows that children enrolled in Medicaid and CHIP are more likely than
17 privately insured or uninsured children to be in fair or poor health and have certain impairments and health
18 conditions. And I know this isn't news to you, but this is just a good resource for the detailed statistics and
19 information that you might want to have on hand.
20 COMMISSIONER EDELSTEIN: April, for people who use this and want a simple way to
21 express it, Table -- are we on Table 3.A, for example, at the moment?
22 MS. GRADY: Expressing this as odds ratios is a handy way for policymakers to look at these and
23 be able to interpret them rather than as in addition to the percentages themselves.

1 MS. GRADY: I'll have to -- we can look at sort of formatting issues and what might be possible
2 for presentation purposes, although -- I'm looking at Chris Peterson -- I'm not sure that's something that
3 we've thought about presentationally.
4 Okay. Moving on to Section 3, which focuses on Medicaid enrollment and benefit spending, a key
5 point in Section 3 is that the mix of Medicaid spending on various services differs significantly by
6 sub-population. So, for example, Figure 3 shows that while -- if you look at the overall Medicaid
7 population in total, about one-third of Medicaid spending is for long-term services and supports, either in
8 the community or in institutions such as nursing facilities and intermediate care facilities for persons with
9 intellectual disabilities.
10 However, what you see when you disaggregate by eligibility group is that nearly all of that long-term
11 care spending is concentrated among enrollees who are eligible on the basis of a disability or who are age 65
12 and older. And what this demonstrates, I think, is that broad statistics on the program as a whole are
13 useful in some contexts, but they really mask substantial underlying variation in the Medicaid population,
14 and this is something we come back to over and over again and something that we will be looking at,
15 obviously, when we do our analysis of dual eligibles over the next year.
16 Another key point in Section 3 is that users of long-term services and supports account for a very
17 small share of enrollees but a majority of Medicaid spending, or a near majority. For example, Figure 5
18 shows that only about 7 percent of enrollees used long-term services and supports in fiscal year 2009, but
19 these individuals accounted for almost half of all Medicaid spending.
20 I just want to point out, you'll note that we identified a smaller number of enrollees as long-term
21 services and supports users this year, in part because we refined our method for identifying HCBS waiver
22 spending in the source data used for these figures, and we have a discussion of the changes that were made
23 in that Section 5 technical guide that I described to you. But essentially what we've done right now is to

1 sort of look at the set of services that most analysts and actually federal regulations and statute are referring
2 to as long-term services and supports at this point. So we have a somewhat more narrowly defined bucket
3 of services at this point.
4 Before I move on, any questions about Section 3?
5 COMMISSIONER COHEN: One quick question. Is the drug spending always -- I'm sorry.
6 Am I going backwards to Figure 3? I am.
7 MS. GRADY: That's okay.
8 COMMISSIONER COHEN: Is there no overlap between the managed care spending and drug
9 spending, or is all drug spending pulled out.
10 MS. GRADY: All drug spending that's shown broken out is paid fee-for-service. So if drugs
11 were included in a managed care contract, they would be in the managed care bar. And you're raising a
12 very good point and one that Commissioners have raised before, which is that we have this problem where
13 managed care spending -- it's not telling you much. We're sort of -- we've got this bucket, and we're not
14 disaggregating for you, and, you know, I'll throw the data under the bus. Unfortunately, we just don't have
15 that underlying detail. I wish we did.
16 It is something that CMS is working on and I think we'll be looking at in the near future. States are
17 reporting some of that encounter data. I know we've had this conversation numerous times. You're
18 probably tired of hearing it. But, you know, within the next few years, we're hopeful that we should be
19 able to begin to disaggregate that managed care bucket so that you can have a better idea of what's going on
20 inside that.
21 COMMISSIONER COHEN: Just because the bigger it gets, the more you don't know. If you
22 disaggregate it, would it really throw the other categories off or not?
23 MS. GRADY: Exactly. And we do know in some states that drugs are carved out of managed

1 care contracts, but going forward, there may be less incentive to do so because rebates will now be paid on
2 drugs in managed care settings, so there could be some interesting analysis for us to pursue.
3 COMMISSIONER COHEN: Okay.
4 MS. GRADY: Okay. How appropriate. We're at Section 4, which is Medicaid managed care
5 now. Here we note that various service delivery models may be referred to as managed care, and this is --
6 it's a technical issue, but it's an important one just for understanding, you know, the numbers that you're
7 looking at in various contexts. This year, we've added some new information on individuals who are dually
8 enrolled in Medicaid and Medicare that we didn't have last year.
9 For example, Table 9 shows that about 9 percent of duals were enrolled in a comprehensive
10 Medicaid managed care plan as of July 1, 2009. However, those individuals were concentrated in a
11 relatively small number of states. I know this is something that you've looked at in the tables that were
12 provided to you as part of the duals demo discussion. And as you know from the discussions we've had in
13 those other sessions, there are questions about how comprehensive Medicaid managed care plans actually
14 work for dual eligibles given that Medicare is generally the primary payer of the kinds of services that are in
15 a comprehensive Medicaid managed care contract.
16 So this section sort of provides statistics on that issue, but the actual analysis and discussion is
17 something that we'll cover in more detail again --
18 CHAIR ROWLAND: But, April, in some of these, they are comprehensive for Medicaid benefits
19 only, and they still can get their Medicare benefit fee-for-service.
20 MS. GRADY: Correct. We are talking about Medicaid managed care, and so --
21 CHAIR ROWLAND: Right. So I think it's important in distinguishing here when the word
22 "comprehensive" is there, I think people automatically think that it includes the full range of benefits.
23 MS. GRADY: Right.

1 CHAIR ROWLAND: And since we're in such a discussion with the duals, I would at least have a
2 footnote explaining how Medicare is interacting with that.
3 MS. GRADY: That's a great point.
4 There should be information from Alaska in there. If it's not, then we have a row missing in the
5 table, and we'll double-check that.
6 Okay. Moving on to Section 5, again, this provides supplemental information on the data and
7 methods that we used in MACStats, and I'll just briefly mention two key issues in this section that are
8 supported by the tables that are shown here on the screen.
9 The first issue is that Medicaid and CHIP enrollment and spending figures will vary depending on
10 the data source that's used and how the figures are calculated, and this is something we discuss in every
11 version, every edition of MACStats because it is a key issue.
12 Tables 13.A through 13.D are new this year and are used as a tool to demonstrate this point. For
13 example, if you look at Table 13.B, what we show here is the number of children who were ever enrolled in
14 Medicaid or CHIP during the year. And if you take that ever-enrolled number, so kids who were in for at
15 least one month during the year, and divide that by the total U.S. population of children under age 19, you
16 find that nearly half -- about 48 percent -- of children in fiscal year 2009 were enrolled in Medicaid and
17 CHIP at some point, so it's rather large. But if you look at an average month -- we've talked about the
18 churn in Medicaid -- not all children are enrolled in Medicaid or CHIP for the entire year. If you look at
19 an average month, the statistic is that a smaller number, closer to about a third of the child population, was
20 enrolled in Medicaid at some point -- I'm sorry, in an average month in 2009.
21 So what we drive home here in this technical guide is just sort of that the time period, the
22 measurement matters, and, you know, you can have many versions of the truth, but it's helpful to know
23 which one you're talking about.

1 The second key issue that we cover here in the technical guide -- again, you've heard over and over
2 again -- is that the Medicaid Statistical Information System, or MSIS data that we use as a key data source in
3 MACStats and in analysis of Medicaid issues generally, is that the MSIS data tends to undercount Medicaid
4 spending relative to the official CMS-64 accounting data that are used to calculate federal matching funds
5 for Medicaid. And we talk about some of the reasons for the discrepancies between these two data
6 sources. And as you might recall from our March report, in the financing chapter we talked a lot about
7 supplemental payments that are made particularly to hospitals that may not show up in the MSIS data but
8 do show up in the accounting -- the CMS-64 accounting data. So we talk about those differences and the
9 fact that the mismatch between these two data sources tends to vary by state, again, depending on their
10 payments and data reporting practices.
11 So as a result, we adjust the MSIS data, the spending data that we have to match the CMS, the
12 official accounting CMS-64 totals, and that's an effort to provide consistent and comparable information
13 across states. We want to make sure that we're doing an apples-to-apples comparison when we calculate
14 spending per enrollee. We want to make sure that we're accounting for all of the spending that's actually
15 going on in that state.
16 So that brings me to the end of our presentation, and I'm happy to take any questions or feedback
17 you might have.
18 VICE CHAIR SUNDWALL: A comment. April, thank you. I'm always amazed at your detail
19 and the scholarship in these reports.
20 My question is this: I should go back and look, because you say this parallels what we did in the
21 June 11th report, and I can't recall how that was formatted. But as I look through this, this is obviously
22 written for people, for the cognoscenti, or however you say it, those in the know on how to analysis this.
23 And it would escape, I think, most Hill staffers to look at this and get much out of it without some hand

1 holding.

2 Is there any way to have a paragraph narrative preceding the tables? I mean, the graphs are fine.
3 I'm a visual guy. I like pie charts and graphs. I can draw conclusions from that. But, you know, when
4 you get these multi-item data point tables, it really is beyond the reach of most people that don't know how
5 to read them. So is there some narrative that could say this table points to these conclusions?

6 MS. GRADY: Absolutely. And, unfortunately, we didn't have that narrative in time for your
7 meeting materials, but we do have that and will share it with you. Essentially for each of the five sections,
8 we have a text including bullet points and key takeaways for each of the sections.

9 VICE CHAIR SUNDWALL: Good. Terrific.

10 MS. GRADY: And that's, you know, something I think that Diane and Lu have both focused on.

11 VICE CHAIR SUNDWALL: And that's what we did last year?

12 MS. GRADY: Correct.

13 VICE CHAIR SUNDWALL: Yes, because last year I recall it was useful, and I could use that --

14 MS. GRADY: Yes. You're looking at some pretty raw information pre-formatting.

15 VICE CHAIR SUNDWALL: Okay, because much of this I should think would be in an appendix
16 or something, but it wouldn't be really helpful if I were on the Hill and trying to digest it. Thank you.

17 CHAIR ROWLAND: And then we do post all this on the Web as well.

18 MS. GRADY: Correct.

19 CHAIR ROWLAND: And we post it independently of the PDF of the whole report.

20 MS. GRADY: Yes, we have it in --

21 CHAIR ROWLAND: So that people can actually go on the Web and just print down one table
22 that they want or whatever.

23 MS. GRADY: And we have it in Excel also, so if they want to manipulate the numbers

1 themselves, they can do that also.

2 COMMISSIONER RILEY: Data, I am just so excited.

3 I dare not make this suggestion, but I wonder if we want to add something to this MACStats. In
4 the March report, there was a phenomenal chart that I've made great use of in the last couple of months
5 which shows state and federal spending and just state spending, and there's a chart that goes Medicaid,
6 education, and it shows how state budgets work. It's phenomenally helpful and very useful information,
7 especially the state-by-state stuff. It would be more so if it added up to 100 percent. So if we showed
8 Medicaid, higher ed, ed -- I think were the three categories -- what else makes the state spending? So that
9 you could look at variation from states in terms of where their commitments are by program, and I think
10 that would be extremely useful to be part of this MACStats, especially if we could take it out fully so that
11 states could compare, because we have just been through a debate in Maine about wanting to make Maine
12 average, and we just cut --

13 [Laughter.]

14 COMMISSIONER CHECKETT: Setting your sights pretty high there.

15 COMMISSIONER RILEY: No, remember, Good, better, best, never let it rest 'til the good is the
16 better and the better is the best. That's my motto. But apparently that's not the Maine motto anymore.
17 So we've just cut significant numbers of people off the program, even though, you know, where Maine isn't
18 average is in the per capita spending on certain populations, it's not populations as a whole, that budget
19 information is extremely useful to have -- states make choices. It's not a value judgment. They make
20 choices. But it's very interesting to be able to look through what choices they make in their state spending.

21 So I would really love to see that as part of MACStats, especially if we could show totals.

22 CHAIR ROWLAND: I think it's also an important table because it shows what the effect of the
23 federal matching funds is on the share of the state budget that goes to health care.

1 COMMISSIONER RILEY: Right.

2 CHAIR ROWLAND: So to do the two, one including the Medicaid and then one that's just state

3 general funds allocation, I think are important ways to assess the fiscal capacity of the states, fiscal choices.

4 MS. GRADY: And as you pointed out, we do have a version of that in the March 2012 MACStats.

5 What we don't have is that extra column or columns showing what the other spending is.

6 I'll go back and double-check, but unfortunately, I think when the National Association of State

7 Budget Officers collects that information, in addition to higher ed, elementary and secondary ed, there

8 might only be one or two other categories, if you like other --

9 CHAIR ROWLAND: I think it has corrections, maybe.

10 MS. GRADY: Corrections, public safety, and then other. So we may not actually be able to

11 disaggregate. We'll double-check that for you.

12 CHAIR ROWLAND: Other comments?

13 [No response.]

14 CHAIR ROWLAND: Thank you, April.

15 VICE CHAIR SUNDWALL: Excellent.

16 CHAIR ROWLAND: If there are any comments that anyone in our very loyal audience would like

17 to make, we would like to hear them now.

18 ### **PUBLIC COMMENT**

19 CHAIR ROWLAND: Otherwise, not hearing -- it's like the banns for a wedding or something.

20 Hearing nothing, we'll go ahead and marry this meeting to its end.

21 [Laughter.]

22 CHAIR ROWLAND: I think that we certainly have a great deal of material that we've covered

23 today. I think we have the June report, which the schedule for that, Lu, do you want to just review

1 quickly?

2 EXECUTIVE DIRECTOR ZAWISTOWICH: The schedule. We are going to the editors by

3 the end of this week, so if you have any -- to use your phrase, if you have any changes, please speak now or

4 forever hold your piece.

5 VICE CHAIR SUNDWALL: Or tomorrow night, as I recall the --

6 [Laughter.]

7 EXECUTIVE DIRECTOR ZAWISTOWICH: Right. No, I think the -- when is the -- it's

8 tomorrow night, right.

9 VICE CHAIR SUNDWALL: It's Wednesday night. Thanks for the leeway. That was great.

10 One day.

11 CHAIR ROWLAND: And then it will come out on June 15th?

12 EXECUTIVE DIRECTOR ZAWISTOWICH: It will come out on June 15th.

13 CHAIR ROWLAND: And be send to you in advance and delivered, and there will be no stickers

14 or changes if the Supreme Court issues its opinion in the next few days. And we will convene again in our

15 public sessions in the fall, but with a summertime time to reflect and pull together in a retreat environment

16 where we've been and where we ought to be going. So enjoy the Memorial Day weekend and the 4th of

17 July weekend, and we'll see you and put you back to work, and let Lu know of anything that you want

18 changed in this report, and we'll keep you abreast of the progress we make on putting together an issue brief

19 on the duals and any of the other issues that come up with regard to the duals, either on our end, on the

20 Department's end, on the states' end, or especially on MedPAC's end.

21 VICE CHAIR SUNDWALL: And you'll share with us the MedPAC letter, if there is one.

22 CHAIR ROWLAND: If and when there is one.

23 VICE CHAIR SUNDWALL: Could I just have the record record our thanks --

1 CHAIR ROWLAND: Norma has --

2 VICE CHAIR SUNDWALL: Go ahead. I was going to just thank the staff.

3 COMMISSIONER MARTINEZ ROGERS: I was going to thank Lu for calling me and clarifying

4 for me information which really helped me look at the data differently, and I thank you for that and thank

5 you for your staff and all the work that they've done.

6 VICE CHAIR SUNDWALL: Hear, hear.

7 CHAIR ROWLAND: Hear, hear.

8 VICE CHAIR SUNDWALL: Thank you. We do appreciate you even though we can't even buy

9 you lunch.

10 CHAIR ROWLAND: And I appreciate those who come and loyally listen to us, and I hope you've

11 received some benefit of the time you spent with us today. And I thank all the Commission members for

12 the effort that they put in not only at these meetings but between these meetings to provide comments and

13 help to the staff; and, of course, to the staff who produce such wonderful reports and who have really

14 stepped up to the plate to produce materials that I think now are really ones that are ready to go to the

15 printer without a lot of us doing line editing and commenting on them. So thank you.

16 VICE CHAIR SUNDWALL: We've come a long way from that. That's great. Okay, thanks.

17 CHAIR ROWLAND: Okay. We're adjourned.

18 [Whereupon, at 4:05 p.m., the public meeting was adjourned.]